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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey, Extended Survey, and Complaint investigation #KS67903, 71855, and 71997. A revised copy of the deficiencies was sent to the facility on 2/13/14.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 74 residents. Based on staff interview and record review the facility failed to notify 1 of 3 residents # 37, prior to discharge from Medicare services.

Findings included:

- Review of the liability notice revealed resident #37 was discharged off Medicare A services on 3/25/13 and the patient was not notified until 4/1/13.

Interview on 1/30/14 at 10:30 A.M. with social service staff KK revealed he/she gave notices to the residents when Medicare services were discontinued and he/she did not give notice prior to the Medicare services being discontinued for this resident.

The facility failed to provide a policy for Medicare A liability notices.

The facility failed to provide timely notice of

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F 156	Continued From page 3 Medicare Provider Non-Coverage.	F 156		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: The facility identified a census of 74 residents. Based on staff interview and record review the facility failed to return resident personal funds within 30 days of death for 2 of 3 residents sampled (#16 and #74). Findings included: - Review of the resident fund account revealed resident #74 died on 10/6/13 and the facility refunded the resident's money on 11/14/13 (39 days). Resident #16 died on 10/12/13 and the facility did not refund the resident's money until 11/14/13 (33 days). Interview on 1/30/14 at 2:00 P.M. administrative staff B stated funds were returned within 30 days or upon discharge or death. The policy and procedure revised on 2/5/2014 for Financial Management stated, the facility was responsible to refund any remaining balances	F 160		

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F 160	Continued From page 4 within 30 days. The facility failed to return personal funds within 30 days of death.	F 160		
F 161 SS=F	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: The facility identified a census of 74 residents and identified 72 residents had a trust fund account with the facility. Based on record review and interview the facility failed to maintain a surety bond in excess of the value of the resident trust fund account. Findings included: - Review of the resident fund surety bond revealed the facility had a surety bond of $31,000. Review of the daily ledger balances for October 2013, November 2013, and December 2013, revealed an account balance of $45,361.68 which occurred on 10/7/13. Interview on 1/28/14 at 1:02 P.M. administrative staff B stated corporate reviewed the resident account balances to monitor for changes that need to be made to the surety bond. On 1/28/14 at 1:34 P.M. administrative staff A	F 161		

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F 161	Continued From page 5 stated the company chief financial officer reviewed over the annual average. He/she agreed the surety bond should be increased. The policy and procedure revised on 2/5/14 for Financial Management stated the facility would maintain a surety bond in excess of the value of the residents trust fund accounts. The facility failed to maintain a surety bond in excess of the value of the resident trust fund account.	F 161		
F 225 SS=L	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

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violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents. Based on observation, interview and record review, the facility failed to conduct a complete investigation and report allegations of abuse, neglect, or exploitation (ANE) for 3 (#68,#42 and #27) of 3 residents sampled for abuse. Resident #68's allegation that licensed nursing staff H threw the resident to the floor, the incident was not reported or thoroughly investigated and he/she continued to work on 2 of 2 resident halls in the facility after the allegation was made which placed the residents in immediate jeopardy (IJ). Resident #42's incident was not reported to the state and #27 had possible exploitation.

Findings included:

- The signed Physician order Sheet (POS) for resident #68 dated 1/2/14 revealed diagnoses of schizoaffective disorder mild type (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought,

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perception and emotional reaction), and mild mental retardation.

The Annual Minimum Data Set (MDS) dated 12/20/2013 revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The resident received antipsychotic and antidepressant medications.

The Cognitive Care Area Assessment (CAA) indicated the resident exhibited disorganized thinking, inattention, delusions and hallucinations related to his/her mental illness.

Review of the care plan dated 1/2/14 revealed the resident had a history of exhibiting anger, both verbal and physical aggression. He/she was involved in numerous altercations with staff and peers.

The Nursing Note dated 12/30/13 at 12:45 A.M., and an incident/accident report dated 12/30/13 at 12:45 P.M. completed by licensed nursing staff H revealed the resident punched licensed nursing staff H in the nose first and then in the mouth, which broke the staff's dentures. During the altercation, the resident tripped and licensed nursing staff H caught the resident before he/she hit the floor. The resident began to yell, "you threw me to the floor."

Review of a witness statement provided by the facility, dated 12/30/13 at 1:45 A.M. completed by direct care staff P, revealed the resident hit licensed nursing staff H in the lip. Licensed nursing staff H blocked several punches at which time the resident fell to the floor on his/her own and became emotional.

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The witness statement provided by the facility dated 12/30/13 at 1:45 A.M., a notarized complaint investigation witness statement dated 1/29/14 at 12:21 P.M., and interview on 1/29/14 at 12:21 P.M. completed by direct care staff O, revealed this staff member witnessed the resident punch licensed nursing staff H in the face then proceeded to fall to the ground by his/her own will. The resident threatened to hit licensed nursing staff H before he/she actually hit licensed nursing staff H. The resident claimed licensed nursing staff H hit him/her but it was clear that did not happen.

The electronic social work note by licensed staff J dated 12/30/13 at 8:29 (does not say A.M. or P.M.) revealed that at 1:33 A.M. licensed nursing staff H reported to licensed staff J the resident walked down the hall, turned around, and started to run towards licensed nursing staff H and hit him/her in the nose and mouth, breaking staff's dentures. The resident tripped and licensed nursing staff H caught him/her before hitting the floor. The resident began to yell, "you threw me to the floor." It was reported the resident stated the voices were telling him/her to hurt others.

The electronic social work note by licensed staff J dated 12/30/13 at 8:40 (does not say A.M. or P.M.) revealed that an unsampled resident requested a confidential interview with staff regarding the incident last night in which he/she witnessed. The resident reported he/she saw staff throw a resident to the floor. The resident completed an undated witness statement form, which revealed the resident was "tron" to the ground.

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The Notarized Complaint Investigation witness statement completed by anonymous staff A dated 1/30/14 revealed the resident was talking to the staff working on his/her hall regarding the incident with licensed nursing staff H the previous week. The resident stated they had got into an argument that escalated to the resident striking licensed nursing staff H, which broke the staff member's dentures. He/she reported staff asked him/her to leave the area and proceeded to shut the doors which blocked the hall in which they were on. The resident stated to this anonymous staff that licensed nursing staff H shoved him/her down the hall and on to the floor.

An undated typed statement from anonymous staff A revealed the resident reported this incident to social service staff KK. This anonymous staff member placed a call and left a message with Adult Protective Services immediately following the resident's report of this incident. Licensed nursing staff H continued to work 5 more shifts after this incident occurred.

A hand written statement by the resident dated 12/29/13 and interview with the resident on 1/29/14 at 8:05 A.M., revealed licensed nursing staff H shoved him/her into another resident's door, the staff had his/her knee in the resident's hip and shoved the resident to the floor which resulted in a small bruise on his/her right knee and a knot on the head. Licensed nursing staff H shut the door so direct care staff O and R could not see what happened.

The Notarized Complaint Investigation witness statement by Administrative nursing staff D dated 1/30/14 revealed this staff member worked with licensed nursing staff H and did not witness any

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abuse, neglect, or exploitation when working with him/her. Administrative nursing staff D did not have any reports that abuse occurred. Administrative staff D reported the resident stated licensed nursing staff H did not abuse him/her and he/she was just upset and sorry upon return from jail.

On 1/29/14 at 7:30 A.M., observation revealed the resident visited with table mates.

On 1/29/14 at 8:45 A.M. administrative staff A reported this altercation between resident and licensed nursing staff H was not reported to the state as he/she and administrative nursing staff D did not think it needed reporting, because staff saw the altercation, read the witness statements and licensed nursing staff H did the right thing.

An interview on 1/29/14 at 8:30 A.M. direct care staff JJ reported the resident recalled situations appropriately yet at times added additional information.

On 1/29/14 at 1:07 P.M. administrative staff A stated when there was any altercation between residents and staff, or other residents, staff started an investigation immediately. He/she said staff reported altercations between residents and staff to the state agency.

On 1/29/14 at 3:00 PM direct care staff O stated he/she worked evening and night shift and stated staff were to report all incidents with resident to staff altercations to the Director of Nursing (DON).

On 1/29/14 at 3:30 P.M. administrative staff A stated he/she did not receive information from the

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resident's perspective of the incident.

On 1/29/14 at 3:40 P.M. with licensed staff J stated when there was an altercation, he/she spoke with the resident and obtained incident reports, yet agreed that in this case there was no documentation anyone spoke with this resident. He/she reported the staff spoke to the resident and he/she acknowledged hitting licensed nursing staff H and reported he/she was shoved to the ground.

On 1/29/14 at 4:19 P.M. administrative nursing staff D stated if there was alleged abuse that during the investigation, the facility would suspend the staff person, and his/her role in the investigation was talking with staff, residents, and reviewing witness statements. He/she was unaware of any alleged abuse in this altercation and did review the incident with administrative staff A, including the nurse's note on 12/30/13 at 12:45 A.M. completed by licensed nursing staff H, and witness reports from direct care staff O and P. He/she was unaware of the witness statements from the unsampled resident and he/she said licensed nursing staff H was not suspended.

Interview on 1/29/14 at 5:10 P.M. anonymous staff A reported the resident told this staff member that he/she got into an argument with licensed nursing staff H and the resident hit licensed nursing staff H. This anonymous staff member was worried because licensed nursing staff H still worked at the facility. This staff member reported during the interview with the resident he/she had to pull information out of the resident which was rare for this resident. The resident said licensed nursing staff H closed the

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doors to the hall and threw the resident to the ground. This anonymous staff member had the resident write a written statement but never turned it in, because the resident had a reputation of making allegations and this staff was off for a week and was not sure what licensed staff H reported. This anonymous staff was worried because usually they suspend nurses who had allegations of abuse and licensed nursing staff H was still working.

On 1/30/14 at 11:27 A.M. administrative staff A was informed of IJ for lack of thoroughly investigating alleged abuse and failure to report this alleged abuse to the State agency, while the staff member named in the allegation continued working at the facility.

On 1/30/14 at 11:27 A.M. administrative staff A stated he/she reported practically everything to the state. He/she reported serious incidents including, resident to resident abuse, resident to staff altercations, and investigations start immediately.

The policy and procedure for ANE last revised on 1/30/14 stated: Investigate each such alleged violation thoroughly, report the results of said investigations to the State agency as required by State and Federal Law and respond to any necessary corrective actions depending on the investigation outcome.

The facility failed to complete a thorough investigation of abuse and exploitation and failed to report an alleged incident of abuse to the State Agency.

This immediate jeopardy was abated on January

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31, 2014 at 4:00 P.M. when the facility revised the facility's ANE policy and procedure, the policy was then translated into terms in which the staff understood, in-serviced staff and residents how to report ANE allegations, training and retraining will occur upon hire, new admission, bi-annually for staff and monthly for residents. The alleged perpetrator was removed from the facility and was not expected to return.

This deficient practice of failure to thoroughly investigate and report an allegation of abuse, exploitation remained at a scope and severity of an F.

- Resident #27's admission Minimum Data Set (MDS) dated 12/6/13 included the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status.

Review of the resident's clinical record revealed the resident was admitted to the facility during the month of 2/2013 and discharged to the community during the month of 3/2013. The resident was admitted to the facility on 11/29/13, discharged to a local hospital on 12/29/13 for a diagnosis of pneumonia (lung infection) and readmitted to the facility on 1/3/14.

On 1/27/2014 at 8:01 A.M. the resident stated upon admission he/she had (3) portable Play Station (PSP), was missing (2) of PSP and $5.00. The resident stated he/she noticed (2) PSP and the $5.00 was missing upon his/his return from the hospital and reported the missing items to social service staff. Housekeeping staff Y entered the resident's room a few minutes later stated after the resident returned from the

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hospital a couple of weeks ago, the resident reported to him/her that he/she was missing $4.00. Housekeeping staff Y stated he/she looked in the resident's pant pocket as well as in laundry and did not find the money. Housekeeping staff stated to the resident "before you accuse someone of stealing and telling this lady/man this, you need to make sure the items are not in your room." Housekeeping staff Y exited the resident's room and a few minutes later housekeeping staff Y and direct care staff S entered the resident's room. Direct care staff S stated to the resident he/she did not bring in (3) PSP's at admission, he/she worked at the facility for a year, conducted the resident's personal inventories and the resident did not have (3) PSP's upon admission. A few minutes later licensed nurse K entered the resident's room and told the resident he/she was not missing PSP's. Observation revealed (1) PSP in the resident's room.

Review of the resident's clinical record lacked evidence the facility performed an inventory of the resident's personal items.

On 1/28/14 at approximately 3:56 P.M. direct care staff CC stated he/she was not aware the resident was missing personal items. Direct staff CC stated direct care staff reported to the charge nurse if residents reported they were missing personal items. Direct care staff CC stated when residents were admitted to the facility, staff did an inventory of the resident's personal items and the inventories were updated every month or so.

On 1/28/14 at approximately 8:30 A.M. direct care staff S stated she and a charge nurse reviewed the resident's chart on 1/27/14 and did not see a

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personal inventory. Direct care staff S stated direct care staff performed the personal inventory upon admission and then gave the inventory sheet to administrative staff E.

On 1/28/14 at approximately 2:25 P.M. administrative nursing staff E confirmed the facility did not perform an inventory of the resident's personal items upon admission.

On 1/28/14 at approximately 2:30 P.M. social service staff KK stated direct care staff did an inventory of the resident's personal items upon admission. Social service staff KK stated the facility determined what actions they took regarding missing items depending upon the resident's cognition and organizational skills. Social service staff KK stated the resident stated he/she was missing items including the PSP (did not give date the resident had reported this). Social service staff KK stated except for the PSP the facility found the other missing items the resident reported. Social service staff KK stated he/she was not aware the resident was missing money until 1/27/14. Social service staff KK stated when residents missed personal items either the resident or staff completed a complaint form and then passed the form on to the licensed social work or the administrator.

On 1/30/14 at approximately 1:25 P.M. social service staff KK stated the facility would report the missing items to the state certification and licensing agency.

On 1/30/14 at approximately 1:40 P.M. direct care staff S stated direct care staff reported resident's missing items to the charge nurse.

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F 225	Continued From page 16 On 2/3/14 at approximately 8:00 A.M. housekeeping staff Y stated staff reported missing reported to the Social Service Designee. Housekeeping staff Y stated he/she did not report the resident's missing $4.00 to the SSD. The facility's Abuse, Neglect, Exploitation/Misappropriation of Property Policy and Procedure revised 1/30/14 included the purpose of the policy was to ensure all alleged violations of Federal or State Laws, including exploitation, and misappropriation of residents property were reported immediately to the facility's Executive Director, and to the state agency in accordance with the existing State law...The Executive Director reported all alleged violations within 24 hours to the state agency. The facility failed to immediately report the alleged misappropriation/exploitation of this resident's personal property to the state agency. x - The Physician's Order Sheet (POS) for resident #42 signed 1/2/14 revealed diagnoses of bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods) and asthma (disorder that caused the airways to narrow causing wheezing and shortness of breath). The quarterly Minimum Data Set (MDS) with an	F 225		

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Assessment Reference Date (ARD) of 10/25/13 indicated a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The resident had verbal behaviors directed towards others, required limited 1 person assistance with bed mobility, transfers, ambulation, toileting, and personal hygiene, extensive 1 person assistance with dressing, supervision and set up with eating, physical help of 1 person with bathing, was not steady but able to stabilize without staff assistance when moving from seated to standing position, with surface to surface transfers, walking, turning around and facing the opposite direction, was steady at all times when moving on and off the toilet, had no upper extremity impairment with range of motion, had impairment on one side of lower extremities, and used a walker and a wheelchair.

The Care Area Assessment (CAA) for cognitive loss dated 4/4/13 revealed the resident was alert and oriented, communicated his/her needs effectively, had a mental illness diagnosis that affected his/her ability in cognitive areas at times, became angry, yelled and cussed, and had periods of organized thinking but at times fluctuated with disorganized thoughts.

The CAA for psychosocial well being dated 4/4/13 revealed the resident got along with his/her roommate and that was only peer he/she had a relationship with, his/her roommate often apologized to others for the resident's angry outbursts. The resident's angry outbursts, aggression, and derogatory behavior towards others led to isolation.

The care plan dated 7/26/13 with no revision date

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revealed the resident had a diagnosis of bipolar disorder and a history of expressing suicidal ideations (thoughts of intentionally causing ones own death). Staff would encourage positive peer relationships, document all expressions of suicidal thoughts and intervene appropriately, offer medications per the medication administration record (MAR) based on charge nurse's assessment, invite him/her to share his/her feelings.

The care plan dated 7/26/13 with no revision date revealed the resident was alert and oriented, made appropriate decisions and set a daily routine, communicated without barriers, and had impaired decision making and communication during anger outbursts. When he/she became upset and yelled he/she was rarely easily redirected, he/she followed staff, blocked staff and yelled repeatedly. Staff attempted to resolve his/her issues although they were usually based on the fact the resident did not want to be in the facility.

A nursing note on 11/30/13 at 1:00 P.M. revealed another resident put his/her hands around this resident's neck. This resident hollered for help. A direct care staff person assisted the resident out of the room. This resident yelled and called the police.

A nursing note on 11/30/13 with no time revealed the police were at the facility and spoke to this resident.

A nursing note on 11/30/13 at 1:30 P.M. revealed social service staff KK was at the facility doing one on one with the resident and administrative nursing staff D was notified of the incident.

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A nursing note on 11/30/13 at 1:35 P.M. revealed administrative staff C was notified of the incident.

A nursing note on 12/1/13 with no time documented revealed the resident was very aggressive, yelled at staff, wanted the other resident involved in the previous incident thrown in jail.

The record lacked further documentation regarding the incident.

The facility provided documentation the resident in question strangled a second resident in the facility on 12/3/14.

The facility provided documentation this incident was reported to the state agency on 12/4/13.

Observation on 1/28/14 at 8:40 A.M. revealed the resident laid on his/her bed with oxygen on, first responders and nursing staff attended to him/her.

Interview on 1/23/14 at 1:08 P.M. with resident #42 said there was a resident who strangled people and he/she lived at the facility until about 3 weeks ago when the police removed him/her from the facility after he/she attempted to strangle someone again. This resident stated he/she called the police, told the staff at the facility, and called Disability Rights of Kansas the second time it happened. This resident reported the facility did nothing to try and keep the offending resident away from him/her, they only told him/her to stay out of the resident's room.

Interview on 1/29/14 at 1:24 P.M. with direct care staff MM revealed the resident who strangled the

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other residents was started on 15 minute checks and when a second incident happened he/she was started on one on one checks. The facility tried to find placement for the resident. He/she was aware of 2 incidents and the resident was transferred somewhere else.

An interview on 1/29/14 at 2:26 P.M. with direct care staff U revealed after the other resident choked resident # 42 he/she was put on 15 minute checks, the resident threatened people all the time, and frequently tried to harm others like when he/she tried to strangle another resident. He/she was unable to recall and new facility interventions for the resident after he/she strangled the second resident to prevent any further incidents. The resident then tried to strangle administrative nursing staff E, the police were called, and the resident was removed from the facility.

An interview on 1/28/14 at 8:40 A.M. with licensed nursing staff K indicated the resident was transported to the hospital. He/she was started on an antibiotic for a urinary tract infection last night and became increasingly confused and his/her condition declined.

An interview on 1/29/14 at 3:26 P.M. with administrative nursing staff D revealed social services worked with the resident to find out why he/she choked people and it went back to the resident wanted to go to jail. The staff performed 15 minute checks, had him/her on 1 on 1, kept him/her out of other resident's rooms, kept him/her in the day room, and redirected him/her. The resident had a delusion he/she needed to be in jail. The resident was sent to a local mental health clinic for screening and deemed safe the

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F 225	Continued From page 21 resident safe to return to the facility. The facility called the police every time the resident did something and the last episode was when he/she choked a staff member, went to jail and then to an acute mental hospital. The incident/accident reporting policy dated 10/2011 provided by the facility revealed incidents and accidents including, but not limited to abuse, neglect, and exploitation allegations and resident to resident incidents must be immediately reported to the state agency by the director of nursing or the administrator within 24 hours. The facility failed to report this reportable incident within a timely manner.	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents. Based on record review and interview the facility failed to incorporate the 6/17/11 Centers for Medicare and Medicaid Services (CMS) letter entitled: "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150 B of the Social Security Act" into the existing facility policy. Findings included:	F 226		

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F 226	Continued From page 22 - Record review on 1/30/14 revealed the facility's undated Abuse, Neglect, and Exploitation/Misappropriation policy and procedure lacked the inclusion of Section 1150 B of the Social Security Act: Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility which took effect 6/17/11. Staff interview on 1/30/14 at 3:30 P.M. with administrative staff A stated she/he was not aware of the Survey and Certification letter 11-30-Nursing Home (NH) (S&C: 11-10-NH) to report reasonable suspicion of a crime in a long-term facility. The facility failed to fully develop written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. The sample included 18 residents. Based upon observation and interview the facility failed to ensure that 1 (#27) of 18 residents were treated with dignity and respect. Findings included:	F 241		

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- Resident #27's admission Minimum Data Set (MDS) dated 12/6/13 included the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status. The MDS identified the resident had hallucinations (sensing things that appear to be real), delusions (false beliefs), and did not have behaviors. The MDS recorded the resident was independent with bed mobility, and required extensive staff assistance with transfers, dressing, toilet use and personal hygiene. The MDS recorded the resident was frequently incontinent of urine.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/12/13 documented the resident was alert, at times had delusions, and hallucinations. The resident exhibited disorganized thinking and inattention. The staff re-directed the resident to reality on a daily basis. At times it was difficult to redirect the resident and the resident deliberately went against what was asked.

The resident's Activities of Daily Living (ADL) CAA:dated 12/12/13 documented the resident required limited to extensive staff assistance with most ADL's.

The resident's urinary incontinence CAA dated 12/12/13 documented the resident exhibited behavioral incontinence. Upon admission the resident was continent then he/she began refusing his/her medications and became noncompliant and was frequently incontinent. Staff placed the resident on a toileting program which decreased his/her incontinent episodes. Staff continued to educate him/her on the

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importance of using the toilet. He/she had a diagnosis of enuresis (bed wetting), which at times can be related to the resident's mental disorders and behaviors. The resident continued to comply with his/her toileting program, which decreased his/her incontinent episodes.

The resident's care plan dated 12/27/13 included the resident frequently sought staff attention/time, staff encouraged him/her to write down issues he/she wanted to discuss and the resident would approach 1 staff with the list. Staff provided positive verbal praise when the resident appropriately utilized staff time and did not re-address issues repeatedly.

On 1/27/2014 at 8:01 A.M. during Stage 1 of the survey, the surveyor was in the resident's room speaking with the resident. The resident asked for the door to remain open. The resident expressed concerns regarding dignity and missing (2) portable Play Stations (PSP) and $5.00. Housekeeping staff Y entered the resident's room without knocking and stated to the resident, "before you accuse someone of stealing and telling this lady/man this, you need to make sure the items were not in your room". Housekeeping staff Y exited the resident's room and a few minutes later housekeeping staff Y and direct care staff S entered the resident's room without knocking. Direct care staff S started speaking to the resident in a rude manner and without regard the resident was conversing with the surveyor. Direct care staff S stated to the resident that he/she did not bring in (3) PSP's at admission. He/she said he/she had worked at the facility for a year, conducted the security inventories and the resident did not have (3) PSP's upon admission. Direct care staff S and

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housekeeping staff Y exited the resident's room. A few minutes later licensed nurse K entered the resident's room after knocking and without waiting for a response to enter. Without regard for the resident who was conversing with the surveyor, licensed nurse K told the resident in a rude tone that he/she was not missing PSP's. The surveyor asked licensed nurse K if he/she could finish speaking with the resident, licensed nurse K toned his/her voice down and after picking up the nebulizer mask on the resident's floor, he/she exited the resident's room.

On 1/29/14 at 7:05 A.M. direct care staff S and licensed social service staff J were in the resident's room, and the resident laid in bed. Licensed administrative staff J stated they were going to get the resident up and shower him/her. Both staff exited the resident's room and the resident sat on the side of his/her bed. Observation revealed the left side of the resident's pants were wet. At approximately 7:10 A.M. direct care staff S and direct care staff Z entered the resident's room. Direct care staff S and direct care staff Z assisted the resident from the bed via a gait belt. Direct care staff S assisted the resident with putting on his/her shoes and then direct care staff S walked the resident from his room down the hallway to the the shower room. Observation revealed the back and left side of of the resident's pants were saturated, the back of the resident's shirt near the bottom was wet and 2 brown colored substances were observed on the back of the resident's shirt. Direct care staff S assisted the resident with removing the incontinent brief and his/her clothes. Direct care staff S stated the resident's clothing were wet with urine.

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F 241	Continued From page 26 On 1/28/14 at approximately 3:56 P.M. direct care staff CC stated staff should treat residents with dignity at all times, staff should not be rude to residents and should not argue with them. On 1/30/14 at approximately 1:40 P.M. direct care staff S stated the resident's bed and clothing were saturated with urine when he/she assisted the resident from the bed on 1/29/14. Direct care staff S stated staff should treat with respect and dignity and should not disagree with residents. On 2/3/14 at 10:53 A.M. licensed nurse K stated staff should treat residents with respect and dignity at all times. On 2/3/14 at approximately 11:30 A.M. administrative nursing staff D stated staff should knock on resident's door before entering, staff should speak respectfully to residents and should not argue with residents. The facility failed to treat this resident in a manner that enhanced his/her self-esteem and self-worth.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents. The sample included 18 residents. Based on observation and interview the facility failed to	F 253		

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provide a comfortable and clean environment for residents on 2 of 2 hallways and one of one activity room for 3 of 6 days on site of the survey.

Findings included:

- Observation during stage one of the survey on 1/23/14 from 11:15 A.M. to 4:30 P.M. and on 1/27/14 from 7:00 A.M. to 3:00 P.M. and during environmental tour on 1/30/11 at 11:00 A.M. with maintenance staff X revealed the following:

On the South Hallway:
* resident rooms were without towels
* unlabeled towel racks
* broken tiles in the bathroom
* brown staining on the ceiling of a resident's room
* bathroom floors dirty
* call light not within reach of a toilet for one bathroom
* toilet bowl dirty and with yellow staining around the base of the toilet
* unlabeled personal care items in the bathroom
* bedroom walls dirty

On the North hallway:
* the bedroom and bathroom floors were dirty
* privacy curtains stained
* resident rooms without towels
* lack of a bathroom door jam in one bathroom
* disrepair of floor tiles
* scuffed marks on closet door
* holes in walls of resident rooms and bathroom
* rust around the toilet bowel
* discolored tile around the toilet bowl
* foul odor in the bathroom
* and mismatched wall paint

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F 253	Continued From page 28 In the activity room downstairs: * an air duct had a missing vent cover Throughout the environmental tour on 01/30/14 maintenance staff X acknowledged the above concerns. The facility failed to provided maintenance and housekeeping services to maintain a sanitary and comfortable interior for the residents.	F 253		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. Based upon observation and interviews the facility failed to ensure comfortable temperature levels for 2 of 2 halls and the elevator that led to a resident's activity area downstairs. Findings included: - On 1/23/14 at approximately 10:30 A.M. a resident on the north hall stated he/she was cold/freezing and the building had been cold since the weather turned cold. The ambient temperature of the resident's room at that time was 65.3 degrees Fahrenheit (F). On 1/23/14 at approximately 10:35 A.M. the	F 257		

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ambient temperature in another room on the north hall was 66.3 F.

On 1/23/14 at approximately 10:40 A.M. a resident on the north hall stated he/she had a lot of blankets on his/her bed, and his/her room was cold since the weather turned cold. The ambient temperature of the resident's room was 71. 2 degrees F.

On 1/23/14 at approximately 11:35 A.M. the ambient temperature of the elevator that leads to the activity area downstairs was 55 degrees F, the activity area downstairs where therapy worked with a resident was 65 degrees F.

On 1/23/14 at approximately 4:00 P.M. ambient temperatures of all the rooms on the north and south hall were recorded. Six of the room's ambient temperature on the north hall were less than 71 degrees F (69.6 degrees F, 69.8 degrees F, 69.4 degrees F, 69.6 degrees F, 64.5 degrees F and 70.3 degrees F), and 1 room on the south hall was 68.3 degrees F.

On 1/23/14 at 12:25 P.M. maintenance staff X stated the facility had 10 heaters, 4 heaters on each hall (North and South) and 6 of the 8 heaters (north and south hall) were working. Maintenance staff X stated 1 heater on each of the halls was not working, 1 duct controlled each side of the north hall and he/she was unsure as to how it effected the halls (which rooms would be cold/hot). Maintenance staff X stated it appeared the north side of the north hall was affected more than the south side of the north hall. Maintenance staff X stated staff telephoned him/her at 4:52 A.M. on 1/19/14 and informed

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F 257	Continued From page 30 him/her the heating unit was not working. Maintenance staff X stated he/she came to the facility and was able to get 3 of the 4 heaters on each hall working. He/she placed a telephone call to a local heating/plumbing company, a representative of the company came to the facility but was unable to fix the heater that was out on the north hall. The company ordered a part which came in on 1/21/14 but the part did not work, the company had to order another part and the part should be in on 1/23/14. Maintenance staff X stated the whole unit on the South hall needed replacing and the facility was obtaining bids. On 1/23/14 at 12:34 P.M. a resident on the south side of the north hall stated sometimes it was so hot in his/her room, he/she could not close his/her door. The resident stated his/her bathroom was extremely hot. On 1/23/14 at 12:43 P.M. a resident that resided on the north side of the south hall stated at night his/her room gets warmer, the temperature in his/her room was okay during the day. The resident stated the dining room was pretty cold at times so residents wore their coats. The resident stated it was very cold in the elevator, and on 1/19/14 when the facility held Bible Study in the basement it was cold. The facility did not provide a policy regarding comfortable temperatures. The facility failed to ensure the ambient temperature in the facility was comfortable.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 74. The sample included 18 residents. Based on observation, record review, and staff interview, the facility failed to develop comprehensive care plans for 2 of 18 sampled residents (#2 and #79).

Findings included:

- The Physician's Order Sheet (POS) signed 1/2/14 revealed diagnoses for #79 of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) with psychotic features (a loss of contact with reality), glaucoma (an abnormal condition of elevated pressure within an eye caused by

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obstruction to the outflow), and loss of the left eye secondary to a car accident.

The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/8/13 revealed a Brief Interview for Mental Status score (BIMS) of 6 indicating severe cognitive impairment. The resident had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind), indicated it was very important to him/her to choose between a tub bath, shower, bed bath, or sponge bath, required limited 1 person assistance for bed mobility, transfers, walking, toilet use, and personal hygiene, supervision and set up for dressing and eating, and physical help of 1 person for bathing, had no upper or lower extremity limitation with range of motion, and did not use a mobility device.

The Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 11/8/13 revealed the resident had an ADL deficit evidenced by his/her need for limited assistance for most of his/her ADL's, his/her gait and balance were slow and lurching, had physical and occupational therapy orders but refused, believed he/she did not need therapy, was unsteady with transfers and ambulation, required limited assistance with personal hygiene, and at times refused help.

A note on care plan review dated 11/26/13 revealed the resident wanted to shower Monday and Thursday in the evening.

The care plan dated 12/16/13 with no revision date revealed the resident had an ADL self-care performance deficit related to mental illness, side effects of medication, visual function, and

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impaired gait. He/she required limited assistance from staff for ADLs, and physical assistance for bathing, at times refused staff assistance because he/she believed he/she was strong enough to perform them on his/her own. For bathing/showering staff would avoid scrubbing and pat dry sensitive skin, check nail length and trim and clean on bath day and as necessary, provide sponge bath when a full bath or shower could not be tolerated, the resident was able to wash his/her face, arms, trunk, and top of legs. Staff would monitor, document, and report changes, potential for improvement, reasons for self-care deficit, expected course, declines in function, praise all efforts at self-care, physical and occupational therapy evaluation and treatment as per doctors orders.

A fall risk assessment dated 11/1/13 revealed a score of 18. A score above 10 indicated high risk.

An undated admission assessment revealed the resident transferred and ambulated independently, was full weight bearing, and required assistance with bathing and grooming.

A nurses note on 1/5/14 at 8:00 A.M. revealed the resident refused a shower from a direct care staff. The nurse offered and gave choices of bath or shower. The resident continued to refuse and became agitated and began cursing.

Review of the nurses' notes revealed no further documentation of refusals to bathe.

Record review of the flow sheets revealed frequent refusal of baths in November 2013, December 2013, and January 2014.

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Record review of behavior monitoring sheets revealed frequent refusal of unspecified cares in November 2013, December 2013, and January 2014.

Observation on 1/28/14 at 1:33 P.M. the resident slept in his/her room.

Observation on 1/29/14 at 1:55 P.M. the resident slept in his/her room.

Interview with direct care staff LL at 1:58 P.M. on 1/29/14 revealed the resident received a bath every other day on the 2nd shift, he/she refused often, if he/she refused, the direct care staff were to offer him/her choices. The resident required 1 person assistance. Direct care staff LL said he/she worked until 6 P.M. and the resident usually bathed after that time.

Interview with direct care staff O at 2:02 P.M. on 1/29/14 revealed he/she worked nights and did not give the resident baths but stated it took a lot of persuasion to give him/her a bath as he/she refused often. If the resident refused staff were to ask him/her at a later time or have someone else ask, and tell the resident his/her spouse wanted him/her to bathe. If the resident continued to refuse he/she told the nurse.

Interview on 1/29/14 at 3:10 P.M. with licensed staff I revealed the resident was to get 2 baths a week, required 1 person assistance, refused baths, was care planned to try and talk him/her into bathing if he/she refused.

Interview on 1/29/14 at 3:30 P.M. with administrative nursing staff D revealed if a

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resident refused a bath he/she expected the direct care staff to attempt again at a later time, try at least 2 twice and notify the charge nurse who involved social service. He/she also expected the nurses to document refusals, and a resident who refused baths would have a care plan addressing refusals and staff approaches.

The facility failed to provide alternate interventions for bathing for this resident when he/she refused baths.

- The 12/9/13 Quarterly minimal data set (MDS) for resident #2 revealed the resident had a prognosis of a life expectancy of 6 months or less. He/she was also received hospice services.

The care area assessment (CAA) dated 9/9/13 revealed he/she entered hospice care on 9/6/13 due to a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The care plan dated 9/11/13 for hospice care revealed the facility would integrate/coordinate with hospice on the plan of care, communication, medication, supplies, and showers.

The care plan lacked documentation as to what supplies hospice provided, how often hospice visited and how the facility communicated with hospice.

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Record review revealed on 9/5/13 a signed telephone order to admit the resident to a local hospice agency with a life expectancy of 6 months or less.

Social service note dated 9/11/13 at 1:05 P.M. revealed the resident was admitted to hospice services and social services would continue to monitor for increased behaviors and intervene accordingly.

Observation on 1/28/14 at 4:40 P.M. revealed the resident rested in bed.

On 1/29/14 at 7:28 A.M. resident ate breakfast independently.

Interview on 1/28/14 at 3:10 P.M. direct care staff U revealed hospice provided briefs and staff was unsure of what days hospice visited the resident.

On 1/28/14 at 4:40 P.M. the resident stated hospice gave him/her a bath on Fridays. He/she said hospice also provided briefs and personal hygiene products.

On 1/29/14 at 8:30 A.M. direct care staff Z stated hospice provided showers but was unsure what else hospice provided for the resident.

On 1/29/14 at 10:34 A.M. with licensed nursing staff I stated the facility communicated with hospice by calling them if there were changes with the resident. When hospice was in the facility, they asked nursing if the resident needed anything. Hospice provided some medications for this resident and that information was located on the medication card.

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F 279	Continued From page 37 On 1/29/14 at 4:00 P.M. with administrative nursing staff D stated hospice was invited to the quarterly care plan meetings where they discussed the resident's care. He/she stated hospice gave the facility a list of what they medical supplies, medications, and services they offered to the resident and it was located in a separate hospice chart. The undated policy and procedure for care plans/hospice lacked to address coordination of cares for a resident who received hospice services. The facility failed to develop an individualized comprehensive care plan which coordinated hospice care for this resident who received hospice care.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. The sample included 18 residents. Based upon record review and interviews the facility failed to perform a urine analysis (UA-the physical, chemical, and microscopic examination of urine) as ordered by the resident's physician in a timely manner for 1 (#1) of the 18 sampled residents. Findings included:	F 281		

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- Resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 11/22/13 identified the resident scored 12 (moderately impaired cognition) on the Brief Interview for Mental Status. The MDS identified the resident had hallucinations (sensing things that appear to be real), delusions (false beliefs), and did not have behaviors. The MDS identified the resident was independent with bed mobility, and locomotion on the unit, required extensive staff assistance with transfers, walking in the room, limited staff assistance with locomotion on the unit, dressing, toilet use and personal hygiene and was occasionally incontinent of urine.

The resident's Activity of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA) dated 5/29/13 documented the resident was continent of bowel and bladder.

The resident's Urinary Incontinent CAA dated 5/29/13 documented the resident was continent of bowel and bladder but required staff assistance with toileting to ensure his/her safety.

The resident's care plan dated 12/9/13 included the resident had a history of urinary tract infections (an infection that could occur anywhere along the urinary tract), staff monitored the resident for changes in his/her urinary status, encouraged the resident to report any incontinence episodes, and assisted the resident if needed with any incontinence episodes. Staff monitored the resident for signs and symptoms of urinary retention (inability to empty the bladder), urinary tract infections and staff notified the physician as needed. The above interventions were in place since 5/29/13.

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A physician's order dated 12/30/13 and timed 2:25 P.M. included the resident's physician ordered the facility to obtain a UA with culture and sensitivity (C&S-done to find out the type of organism and what medication worked appropriately to treat) due to resident had difficulty voiding.

A nurse's note dated 1/6/14 and timed 10:40 A.M. documented the UA was not obtained as the physician ordered on 12/30/13.

A nurse's note dated 1/6/14 and timed 2:20 P.M. documented the resident fell a second time that day, and the resident's pants were soaked.

Review of a UA with a collection date of 1/7/14 (8 days after the facility received the order) documented the UA was positive for nitrites (bacteria that caused UTIs), and many bacteria (germs) observed. The C&S dated 1/11/14 showed greater than 100,000/milliliter (ml) of S. warneri (Staphylococcus warneri-a type of bacteria).

A physician's order dated 1/11/14 and not timed included for the facility to start the resident on Doxycycline (an antibiotic) 100 milligrams (mg) twice a day for 7 days.

On 1/28/14 at 8:40 A.M. direct care staff W and direct care staff BB transferred the resident from the wheelchair to the bed. Observation revealed the resident's pants were wet with urine.

On 2/3/14 at approximately 9:00 A.M. licensed nurse K stated the resident was incontinent of urine therefore when staff attempted to obtain the UA, the resident was either incontinent or staff

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F 281	Continued From page 40 was unable to obtain the UA. The facility's Urinary Incontinence Policy and Procedure dated 5/2008 included residents incontinent of bladder would receive appropriate treatment to prevent UTI's. The facility failed to obtain the UA as physician ordered in a timely manner for this resident with a history of urinary tract infections.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. The sample included 18 residents. Based upon record review and interviews the facility failed to consistently assess the respiratory status for 1 (#27) of 2 residents sampled for hospitalization. Findings included: - Resident #27's admission Minimum Data Set (MDS) dated 12/6/13 included the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status. The MDS recorded the resident was independent with bed mobility, required extensive staff assistance with transfers,	F 309		

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dressing, toilet use, and personal hygiene.

The resident's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 12/12/13 documented the resident required limited to extensive staff assistance with most ADLS.

The resident's interim care plan dated 12/21/13 included the resident received Azithromycin ("Z pak" an antibiotic) for a upper respiratory infection (infection in the the nose, nasal cavity, mouth, throat or the voice box). The care plan did not include assessing the resident's respiratory status.
A physician's order dated 12/4/13 and not timed included for the resident to have a chest x-ray, and staff to titrate (adjust) the resident's oxygen to keep the resident's oxygen saturation rate (amount of oxygen in the blood) above 90 percent, and to receive Duoneb (medication used to open the airways) four times a day for 5 days then every 4 hours as needed, Levaquin (an antibiotic) 500 milligrams a day for 7 days, and to discontinue the prior order for Bactrim (an antibiotic).

An X-ray report dated 12/4/13 included the resident had minimal right lower lobe infiltrate (lung infection).

A physician progress note dated 12/11/13 and not timed documented the resident arrived to the facility a couple of days ago (the resident was admitted to the facility on 11/29/13). After arrival, the resident had a cough. On December 4 th, a chest x-ray was ordered that showed a right lower lobe infiltration, and the resident was placed on Levaquin (an antibiotic) 500 milligrams daily for 7 days as well as nebulizer treatments. The

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resident completed the 7 day course of the Levaquin. The resident's blood pressure was 102/85, heart rate was 71 beats per minute, respirations were 16 breaths per minute, and the resident's oxygen saturation rate was 98 percent room air. The impression and plan included the resident had resolving right lower lobe healthcare associated pneumonia (infection in the lung) and the physician did not think any further testing was indicated at that time.

A physician's order dated 12/20/13 and not timed included for the resident to receive a Z pak for 5 days as directed for an upper respiratory infection.

A physician's order dated 12/21/13 and not timed included for the resident to receive a Z pak, 2 tabs and then 1 tab daily for 4 days.

A nurse's note dated 12/20/13 and timed 3:30 P.M. documented the resident had a productive cough with yellow phlegm (thick mucus), and poor lung sounds. The facility contacted the resident's physician and received a physician's order for the resident to receive a Z-pak for 5 days.

A nurse's note dated 12/21/13 and timed 6:00 A.M. documented the resident continued on antibiotic therapy without any adverse effects and the resident did not voice any complaints. The note did not include assessment of the resident's respiratory status.

A nurse's note dated 12/21/13 and timed 10:30 A.M. documented the resident started on the Z-pak. The note did not include assessment of the resident's respiratory status.

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A nurse's note dated 12/21/13 and timed 4:30 P.M. documented the resident continued on an antibiotic for an upper respiratory infection without adverse effects. The resident did not have a cough, the resident's lungs sounds were decreased but clear and the resident's oxygen saturation rate was 95 percent (%) on room air.

A nurse's note dated 12/22/13 and not timed documented the resident refused his/her night medications. The note did not include assessment of the resident's respiratory status.

A nurse's note dated 12/22/13 and timed 10:00 A.M. documented the resident initially refused his/her A.M. medications but did take them after much coaxing. The resident's lungs continued to sound decreased, the resident did not have a cough and the resident's oxygen saturation rate was 97% on room air.

A nurse's note dated 12/23/13 and not timed documented about physical therapy but did not include assessment of the resident's respiratory status.

A nurse's note dated 12/23/13 and timed 4:30 P.M. documented the resident continued on an antibiotic for an upper respiratory infection (URI) without adverse effects, the resident was afebrile (without a fever), and no cough was noted. The note did not include assessment of the resident's respiratory status.

A nurse's note dated 12/24/13 and timed 5:45 P.M. documented the resident's temperature was 97.8 degrees Fahrenheit (F), and the resident continued on an antibiotic for a URI without

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adverse effects. The resident continued with an occasional productive cough with yellow colored phlegm.

A nurse's note dated 12/26/13 and timed 5:42 A.M. documented the resident continued on antibiotic therapy without any signs or symptoms of adverse effects. The resident's temperature was 98.0 degrees F and the resident offered no complaints of pain. The note did not include an assessment of the resident's respiratory status.

A nurse's note dated 12/26/13 and timed 6:00 P.M. documented the resident's breath sounds were very coarse and staff administered Duoneb as ordered.

A nurse's note dated 12/27/13 and not timed documented the resident continued on the antibiotic without adverse effects and the resident did not complain of pain or discomfort. The note did not include an assessment of the resident's respiratory status.

A nurse's noted dated 12/28/13 and timed 3:36 A.M. documented the resident continued to receive antibiotic therapy without any signs or symptoms of adverse effects. The note did not include an assessment of the resident's respiratory status.

A nurse's note dated 12/28/13 and timed 5:00 P.M. documented the resident completed the antibiotic therapy for the URI, the resident's lung sounds were decreased, no cough noted and the resident's oxygen saturation rate was 94%. The resident initially refused to get up for meals, the resident's appetite was poor, and the resident stated he/she was just not hungry or did not want

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to eat. Staff received a physician order for the resident to receive Resource 2.0 (a nutritional supplement) 120 cubic centimeters three times a day.

A nurse's note dated 12/29/13 and timed 4:00 P.M. documented the resident's appetite remained poor.

A nurse's note dated 12/30/13 and timed 5:50 P.M. documented the resident used his/her ancillary muscles (secondary muscles to help maintain adequate respiration) to breathe, and staff administered the respiratory treatment as ordered. The note did not include an assessment of the resident's respiratory status.

A nurse's note dated 12/30/13 and timed 6:30 P.M. documented the nurse was summoned to the resident's room, the resident laid in the supine position with the nebulizer treatment in progress, and had difficulty breathing. The resident's respirations were 38, the resident's temperature was 99.6 degrees F, blood pressure was 83/52, and the resident's pulse rate was 92. Staff notified the resident's primary care physician and received a physician's order to transfer the resident to a local hospital's emergency department (ED) for evaluation and treatment. The note included the resident was transferred to the hospital via emergency medical services.

A hospital's History and Physical dated 12/30/13 documented the resident presented to the hospital's ED with health care associated pneumonia. The resident looked severely ill, the ED noted the resident was hypoxic (insufficient concentration of oxygen in the blood), and the resident was given aggressive antibiotics in the

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ED. The resident's blood pressure was 106/70, heart rate was 105 beats per minute, temperature was 99.2 degrees Fahrenheit, and the resident's respiratory rate was 26 . The physician's assessment was the resident had health-care associated pneumonia, acute respiratory failure with hypoxia, (acute lack of oxygen delivery to the blood by the respiratory system, sepsis (infection in the blood) and thrombocytopenia (low platelet count).

A nurse's note dated 1/3/13 and timed 2:50 P.M. documented the resident returned to facility.

On 1/27/2014 at 8:01 A.M. the resident sat on the side of his/her bed and observation revealed the resident's nebulizer mask was on the floor.

On 1/29/14 at 7:05 A.M. the resident laid in bed and observation revealed the resident's nebulizer mask was on the floor.

On 1/30/14 at approximately 10:15 A.M. the resident sat in a chair near his/her roommate's bed. Observation revealed the resident's nebulizer mask was on the floor.

On 2/3/14 at approximately 10:55 A.M. licensed nurse K stated staff should access the resident's respiratory status and document the findings in the nurse's notes when a resident received antibiotics for an URI.

On 2/3/14 at approximately 11:30 A.M. administrative nursing staff D stated staff should access the respiratory status and document the findings in the resident's clinical record.

The facility's Medication Administration Policy

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F 309	Continued From page 47 revised 8/2012 did not include assessment of residents when he/she received an antibiotic. The facility failed to consistently assess and document the status of this resident's respiratory status, with a URI and a history of pneumonia while the resident received an antibiotic from 12/21/13 to 12/28/13. The resident was hospitalized on 12/30/13 with a diagnosis of pneumonia.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility identified a census of 74 residents. The sample included 18 residents. Based on observation, record review, and staff interview, the facility failed to provide baths for 1 of 5 residents (#79). Findings included: - The Physician's Order Sheet (POS) signed 1/2/14 for #79 revealed diagnoses of bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods) with psychotic features (a loss of contact with reality), glaucoma (an abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), and loss of the left eye	F 312		

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secondary to a car accident.

An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/8/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The resident had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind), and it was very important to the resident to choose between a tub bath, a shower, a bed bath, and a sponge bath.

The resident required limited assistance of 1 person for bed mobility, transfers, walking, toilet use, and personal hygiene, supervision and set up for dressing and eating, physical help of 1 person for bathing.

The Care Area Assessment (CAA) for Activities of Daily Living (ADLs) dated 11/8/13 revealed the resident had an ADL deficit evidenced by his/her need for limited assistance for most ADLs, was unsteady with transfers and ambulation, required limited assistance with personal hygiene, and refused help.

The care plan dated 12/16/13 with no revision date revealed the resident had an ADL self-care performance deficit related to mental illness, side effects of medication, visual function, and impaired gait. He/she required limited assistance from nursing staff for ADLs, and physical assistance for bathing, and at times refused staff assistance. For bathing/showering staff avoided scrubbing and patted dry sensitive skin, checked nail length and trimmed and cleaned on bath days and as necessary, and provided a sponge bath when a full bath or shower was not tolerated.

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The resident was able to wash his/her face, arms, trunk, and top of legs. Other interventions listed were for staff to monitor, document, and report changes, potential for improvement, reasons for self care deficits, and expected declines in function, and to praise all efforts at self care.

Record review revealed a note on a care plan review dated 11/26/13 that indicated the resident wanted to shower Mondays and Thursdays in the evening.

A fall risk assessment dated 11/1/13 indicated a score of 18. A score above 10 indicated a high risk for falls.

An undated admission assessment indicated the resident transferred and ambulated independently, was full weight bearing, and required assistance with bathing and grooming.

November 2013 flow sheets indicated the resident received 4 showers: the 3rd, 12 th, 23 rd, and the 28 th. Six refusals were documented: the 5 th, 9 th, 10 th, 16 th, 19 th, and the 24 th. The record lacked documentation on the day shift 2 of 30 days, on the evening shift 4 of 30 evenings, and on the night shift 5 of 30 nights.

December 2013 flow sheets indicated the resident received 6 showers: the 10 th, 12 th, 17 th, 27 th, 28 th, and 31 st. Seven refusals were documented: the 3rd, 7 th, 14 th, 18 th, 21 st, 22 nd, and 23 rd. The record lacked documentation on the day shift 2 out of 31 days, on the evening shift 5 out of 31 evenings, and on the night shift 13 out of 31 nights.

January 2014 flow sheets indicated the resident

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received 7 showers: the 5 th, 9 th, 14 th, 16 th, 18 th, 25 th, and the 29 th. Staff documented refusals on the 2nd, 4 th, 7 th, 11 th, and the 23 rd.

A nurse's note dated 1/5/14 at 8:00 A.M. revealed the resident refused a shower from direct care staff. The nurse offered and gave a choice of a bath or shower but the resident continued to refuse and became agitated and began cursing.

The record lacked further documentation of refusals of baths.

Observation on 1/28/14 at 1:33 P.M. the resident slept in his/her room.

Observation on 1/29/14 at 1:55 P.M. the resident slept in his/her room.

A 1/29/14 interview at 1:58 P.M. with direct care staff LL revealed the resident got a bath every other day on 2nd shift and refused frequently. If the resident refused, direct care staff gave him/her choices about the bath. The resident required 1 person assistance. Direct care staff LL worked until 6:00 P.M. and stated the resident usually received baths after that time.

During an interview on 1/29/14 at 2:02 P.M. direct care staff O who normally worked nights stated he/she did not bath the resident but knew the resident took a lot of persuasion to take a bath and often refused. He/she stated if the resident refused he/she tried at a later time, had another staff member attempt, informed the resident that his/her spouse wanted him/her to take a bath, and informed the nurse of the refusal.

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A 1/29/14 interview at 3:10 P.M. with licensed staff I revealed the resident was to receive 2 baths a week, required 1 person assistance with ADLs, and the resident often refused baths. It was care planned for staff to attempt to get the resident to take a bath and if he/she refused a bath then the direct care staff charted an "R" on the bath sheet and the nurse passed it on to next shift for them to attempt to give the resident a bath. The nurse did not usually chart refusals unless both baths in a week were refused, then they might chart that in the nurses notes and they would notify the psychiatric advanced registered nurse practitioner (ARNP) for a consultation. If a resident refused baths nursing staff made sure the resident changed their clothing.

A 1/29/14 interview at 3:30 P.M. with administrative nursing staff D revealed he/she expect the direct care staff to attempt again at a later time, at least 2 times if a resident refused a bath, tell the charge nurse and involve social services. He/she also expected the nurses to document refusals in the nurses notes and if a resident often refused cares then staff should care plan interventions on how to approach him/her.

The policy and procedure for refusal of ADL care with a revision date of 9/2011, provided by the facility, revealed all investigation of refusal, education and offering of alternate options were documented in the nurses notes and the care plan was updated as needed.

The facility failed to provide baths for this cognitively impaired who required assistance with bathing.

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 74 residents. The sample was 18 residents. Based on observation, record review and interview, the facility failed to thoroughly assess the resident's urinary pattern to develop an individualized toileting program for 1 (#27) of 3 residents sampled for urinary incontinence.

Findings included:

- Resident #27's admission Minimum Data Set (MDS) dated 12/6/13 included the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status. The MDS recorded the resident was independent with bed mobility, required extensive staff assistance with transfers, dressing, toilet use and personal hygiene. The MDS recorded the resident was frequently incontinent of urine.

The resident's Activities of Daily Living (ADL) CAA:dated 12/12/13 documented the resident required limited to extensive staff assistance with

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most ADL's.

The resident's urinary incontinence CAA dated 12/12/13 documented the resident exhibited behavioral incontinence. Upon admission the resident was continent then he/she began refusing his/her medications, became noncompliant and was frequently incontinent. Staff placed the resident on a toileting program which decreased his/her incontinent episodes. Staff continued to educate him/her on the importance of using the toilet. He/she had a diagnosis of enuresis (bed wetting), which at times can be related to the resident's mental disorders and behaviors. The resident continued to comply with his/her toileting program, which decreased his/her incontinent episodes.

The resident's care plan dated 12/27/13 included an entry dated 1/6/14 that included staff provided supplies and set up as needed, and cued/assisted to toilet before and after meals, upon rising, before bed and with routine rounds during the night. Staff monitored the resident for urinary incontinence.

The resident's Bladder Incontinence Evaluation dated 11/29/13 (date the resident was admitted to the facility) documented the resident had daily incontinent episodes, and was unable to participate in program due to unspecified psychosis (lost of contact with reality) and paranoid schizophrenia (mental illness in which a person lost touch with reality). An entry on the evaluation dated 12/23/13 and timed 11:00 A.M. documented the facility placed the resident on a on a cueing/toileting program, the resident refused to change his/her incontinent pull-up and at times did not wear an incontinent brief. The

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resident needed staff assistance with changing his/her briefs and clothes depending on the resident's physical and mental status. The evaluation did not include the resident's type of incontinence.

Review of the resident's 3 day voiding diary conducted 1/3/14 to 1/5/14 revealed the facility did not consistently document the resident's voiding pattern on the diary.

On 1/29/14 at 7:05 A.M. direct care staff S and licensed social service staff J were in the resident's room, and the resident laid in bed. Licensed administrative staff J stated they were going to get the resident up and shower him/her. Both staff exited the resident's room and the resident sat on the side of his/her bed. Observation revealed the left side of the resident's pants were wet. At approximately 7:10 A.M. direct care staff S and direct care staff Z entered the resident's room. Direct care staff S and direct care staff Z assisted the resident from the bed via a gait belt. Direct care staff S assisted the resident with putting on his/her shoes and then direct care staff S walked the resident from his room down the hallway to the the shower room. Observation revealed the back and left side of of the resident's pants were saturated, the back of the resident's shirt near the bottom was wet, and had 2 brown colored substances on the back of the resident's shirt. Direct care staff S assisted the resident with removing the incontinent brief and his/her clothes. Direct care staff S stated the resident's clothing were wet with urine.

On 1/30/14 at approximately 10:15 A.M. the resident sat in a chair on his/her roommate's side

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of the room. Observation revealed the resident's linens (sheets and bedspread) were on the floor next to his/her bed. Housekeeping staff GG cleaned the resident's bathroom during that time. Housekeeping staff GG stated staff just "changed" the resident and he/she just changed the linens on the resident's bed. Housekeeping staff GG stated the resident's linens were soaked with urine.

On 1/28/14 at approximately 3:56 P.M. direct care staff CC said the resident was incontinent of urine at times, and staff toileted the resident every 2 hours.

On 1/30/13 at 1:38 P.M. direct care staff S stated staff offered to toilet the resident every hour or 2, and night shift staff toileted the resident every 2 hours. Direct care staff stated when he/she assisted the resident out of bed on the morning of 1/29/1/4 (prior to assisting the resident with his/her shower), the resident's bed was soaked with urine.

On 2/3/14 at 10:53 A.M. licensed nurse K stated the resident was incontinent of urine at times and the resident was not on a toileting program.

On 2/3/14 at approximately 11:30 A.M. administrative nursing staff D stated during the day staff cued the resident to toilet and at night staff toileted the resident every two hours.

The facility's Bowel and Bladder Incontinence Policy and Procedure revised 2/2008 included each resident incontinent of urine or bowel was identified, assessed, provided appropriate treatment and services to achieve or maintain as much normal function as possible.

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F 315	Continued From page 56 The facility failed to thoroughly assess this resident's urinary pattern to develop an individualized toileting program for this resident who was incontinent of urine.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. The sample included 18 residents. Based upon observation, record review and interviews the facility failed to provide adequate supervision and/or place timely effective interventions to prevent falls for 1 (#1) of 2 residents sampled for accidents, failed to ensure water temperatures were at an acceptable level for 1 of 6 days of the survey and failed to ensure that resident's rooms that not have space heaters for 2 of 6 days of the survey. Findings included: - Resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 11/22/13 identified the resident scored 12 (moderately impaired cognition) on the Brief Interview for Mental Status. The MDS	F 323		

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identified the resident was independent with bed mobility and with locomotion on the unit, required extensive staff assistance with transfers, walking in the room, limited staff assistance with locomotion on the unit, dressing, toilet use and personal hygiene. The resident was not steady and was only able to stabilize with human assistance with walking, turning and facing the opposite direction while walking, moving on/off the toilet, and surface to surface transfers, had impairment on both sides of his/her lower extremities, and had 2 or more non injury falls since the prior assessment.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 5/29/13 documented the resident was alert, able to communicate his/her needs, was challenged by his/her mental illness, and had periods of disorganized thinking.

The resident's Activities of Daily Living (ADL) Functional/Rehabilitation CAA dated 5/29/13 documented the resident had a significant decline in his ADLs, used a wheelchair for mobility and was working with therapy but was not able to get back to his/her previous walking ability. The resident needed assistance with dressing and bed mobility. The resident refused alarms for safety, desired to be as independent as possible, and he/she was able to transfer with supervision only.

The resident's Fall CAA dated 5/29/13 documented the resident was at risk for falls and fell during the review period. Staff assisted the resident for safety and continued with therapy services to attempt to get him/her back to his/her previous walking level. The resident used a

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wheelchair due to his/her recent decline and falls.

The resident's Fall Risk assessments dated 9/12/13 identified the resident scored 10, on 10/29/13 the resident's scored 10, on 11/2513 the resident scored 12 and on 12/5/13 the resident scored 17 (according to the legend a total score above 10 represented the resident was at high risk for falls).

The resident's care plan reviewed on 12/19/13 included the resident was at high risk for fall related to his/her psychotropic medication usage, history of falls, and a decline in physical status. The resident refused staff assistance, and utilized a wheelchair for mobility. The resident exhibited poor impulse control and poor safety awareness, was noncompliant with staff assistance after verbalizing understanding on education and encouragement and safety concerns. The resident became demanding and agitated when educated or cued. The resident's bathroom had grab bars (effective since 5/29/13). Since 9/22/13 the resident utilized a chair alarm at all times and since 9/28/13 the resident utilized a bed alarm at all times, staff performed 15 minute checks on the 2 P.M. to 10 P.M. shift and the 10 P.M. to 6 A.M. shift since 11/8/13 and 15 minute checks indefinitely since 11/25/13. An entry dated 12/30/13 included the resident needed extensive staff assistance with ADLs, physical and occupation therapy evaluated and treated the resident for gait training. An entry dated 1/23/14 included the resident required 2 staff assistance with transfers.

The resident's fall risk intervention options care plan included the following dates and intervention: 1/13/14 staff lowered the resident's bed to a low

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position and on 1/6/14 staff offered prompted toileting to the resident.

A nurse's note dated 6/8/13 and timed 8:00 P.M. documented staff found the resident on the floor and the resident stated he/she attempted to go to the toilet. Interventions included the staff placed the resident on 15 minute checks.

A nurse's note dated 8/12/13 and timed 7:00 P.M. included the resident stated he/she did not hit his/her head, had some pain in his/her right upper thigh at the time of the fall. The note did not include the location of the fall. Interventions included 15 minute checks and orthostatic blood pressure for 72 hours.

A nurse's note dated 9/14/13 and timed 1:30 P.M. documented the resident laid on his/her right side between the bathroom door and the bedside table. The resident stated he/she slid trying to reach the toilet. Interventions included staff rearranged the resident's room and educated the resident about the risk for falls.

A nurse's note dated 9/22/13 and timed 9:54 A.M. documented at 6:30 A.M. other residents yelled for help, the resident fell from the left side of the wheelchair. The resident stated he/she attempted to transfer to a bench beside the patio door. The resident was angry because he/she was in the wrong wheelchair and there was no alarm on the wheelchair. Staff found the resident's wheelchair with the alarm and put the alarm on. According to the facility's Incident/Accident report intervention included a chair alarm.

A nurse's note dated 9/22/13 and timed 9:00 P.M.

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documented at 7:55 P.M. the resident sat on the floor in the day room in front of the couch. The resident stated he/she was going to walk to his/her room. Two staff assisted the resident into the wheelchair and placed the alarm on the wheelchair. Interventions included staff instructed the cognitively impaired resident to not remove the alarm.

A nurse's note dated 9/28/13 and timed 1:20 P.M., documented staff observed the resident on the floor, the resident could not say what happened, and staff reset the chair alarm. The note did not include if the alarm activated prior to the fall. According to the facility's Incident/Accident report dated 9/28/13 interventions included the facility was planned to keep the resident in the dining room and to use bed/chair alarm at all times.

A nurse's note dated 10/8/13 and timed 8:30 P.M. included the resident was outside on the patio with peers and one staff when the resident and another resident had a confrontation. The resident got out of his/her wheelchair and fell to the ground.

A nurse's note dated 10/23/13 and timed 11:15 P.M. documented staff observed the resident on his/her back on the floor in his/her room. The resident stated he/she was walking back to bed and lost his/her balance. Staff educated this cognitively impaired resident on the use of call light and asking staff assistance with transfers. Staff assisted the resident to bed and placed his/her call light in place. Interventions included staff placed the bed alarm in a different position, and applied grab bars in the resident's bathroom..

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A nurse's note dated 11/2/13 and timed 6:10 A.M. documented the resident sat on the floor in the doorway of his/her bathroom with his/her pants down around his/her ankles. The resident's pants were wet and staff changed the resident's pants. According to the facility's Incident/Accident report, the intervention included referral to restorative nursing.

A nurse's note dated 11/2/13 and timed 9:39 P.M. included staff continued to monitor the resident, checked on the resident every 15 minutes and offered toileting to the resident to toilet every 2 hours.

A nurse's note dated 11/18/13 and not timed documented staff observed the resident on the floor at 7:30 P.M. The resident stated he/she hit his/her head on the door and 15 minute checks continued.

A nurse's note dated 11/20/13 and timed 5:00 P.M. documented the facility provided 1 on 1 staff assistance (1 staff with the resident at all times) due to the resident's falls.

A nurse's note dated 11/25/13 and timed 12:45 A.M. documented staff observed the resident on the floor in the living area. The resident stated he/she was transferring self from wheelchair to chair by himself/herself. Staff educated this cognitively impaired resident to ask for staff assistance prior to transferring. The note included the chair alarm was in place but did not include whether or not the alarm activated. The fall intervention included staff continue with 15 minute checks.

A nurse's note dated 12/3/13 and timed 9:00 A.M.

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documented staff found the resident on the floor between his/her bathroom and wheelchair, the resident hit his/her head and had a hematoma to right temporal area. Intervention included a handrail added to the resident's bathroom to assist with transfers.

A nurse's note dated 12/5/13 and not timed documented that at approximately 7:30 (does not specify A.M. or P.M.) the resident sat on the floor. The resident stated he/she reached for the coffee cup, the resident's wheelchair was not locked and the resident fell from the wheel chair. Interventions included an anti roll back wheelchair.

A nurse's note dated 12/23/13 and timed 12:30 A.M. documented the resident was on the floor outside of his/her bathroom door, the resident stated he/she went to the bathroom by himself/herself and forgot to use the call light. The note included the resident was confused at times. The note included the resident sustained a 1 centimeter (cm) by 0.5 cm abrasion to his/her left elbow. Intervention included staff educated this cognitively impaired resident and placed non slip strips/grips in front of the resident's toilet and staff was to not leave the resident unattended when in the bathroom.

A nurse's note dated 12/23/13 and timed 1:10 P.M. documented the resident was in a semi-reclining position on his/her left side on the patio.

A nurse's note dated 1/5/14 and timed 9:00 A.M. documented staff found the resident on the floor beside his/her bed. The resident's call light was within easy access. Staff instructed this

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cognitively impaired resident to activate his/her call light to prevent falls. According to the facility's Incident/Accident report interventions included: an enabler bar, 15 minute checks, educated the staff, the resident, and the resident's family. The form did not include what education the facility provided.

A nurse's note dated 1/6/14 and timed 11:30 A.M. documented the facility received a physician's order for the resident to have an enabler bar to his/her bed to promote independence with bed mobility and assist with transfers.

A nurse's note dated 1/6/14 and timed 10:40 A.M. documented the resident was on the floor. The facility's 1/6/14 Incident/Accident Report included interventions the facility would attempt to obtain a urine analysis, an enabler bar, staff was to not leave the resident alone in his/her room, and the resident must be in the dining room.

A nurse's dated 1/6/14 and timed 2:20 P.M. documented the resident fell a second time at approximately 2:30 P.M. Staff instructed this cognitively impaired resident to ask for help.

A nurse's note dated 1/8/14 and not timed documented staff asked the resident not to shut off alarms and to allow staff to assist him/her as needed.

A nurse's note dated 1/11/14 and not timed documented the resident had an unwitnessed fall in the main dining room.

A nurse's note dated 1/15/14 and timed 1:15 P.M. documented the resident laid on the floor in front of the mirror and he/she stated he/she was trying

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to make coffee. Staff reminded the resident to ask for staff assistance. According to the facility's Incident/Accident report dated 1/15/14 interventions included staff removed the microwave, staff educated the cognitively impaired resident, the resident continued to receive therapy, staff continued with 15 minute checks and the facility performed a medication review.

According to the facility's incident/accident log the facility requested an evaluation of the resident's room by an occupational therapist.

A nurse's note dated 1/24/13 and timed 1:35 P.M. included the resident had a non injury unwitnessed fall in the bathroom.

According to the facility's incident/accident log the facility transferred the resident to a different room which allowed the resident better access to the bathroom.

On 1/27/14 at 3:26 P.M. the resident sat in his/her wheelchair. Observation revealed a chair alarm located near the seat of the resident's wheelchair.

On 1/27/14 at 4:10 P.M. observation revealed the resident's bed was not in a low position, and non-strip strips and grab bars were in the resident's bathroom.

On 1/28/14 at 7:19 A.M. the resident sat in his/her wheelchair in the dining room with the chair alarm in place.

On 1/28/14 at 8:15 A.M. the resident sat outside on the patio in his/her wheelchair. Observation revealed a staff member was outside with the

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resident.

On 1/28/14 at 8:40 A.M. direct care staff W and BB transferred the resident with a gait belt from the wheelchair to the bed. Observation revealed the resident's bed was at least 5 inches from the ground. Observation revealed a bed alarm in place but no handrail observed.

On 1/28/14 at 9:31 A.M. the resident was in bed. Observation revealed the height of the resident's bed frame to the floor was 8 inches and the height from the resident's mattress to the floor was 17 inches. Observation revealed the resident's bed alarm was within the resident's reach.

On 1/28/14 at 3:15 P.M. observation revealed the resident was transferred from the north hall to the south hall. Observation revealed (2) quarter side rails on the resident's bed. Observation revealed the resident did not have an enabler bar.

On 1/29/14 from 9:40 A.M. to 9:45 A.M. observation revealed the resident sat in his/her room without staff.

On 1/29/14 at 11:00 A.M. the resident sat by the patio door in his/her wheelchair, another resident asked direct care AA to assist in opening the door. After a resident pushed the resident to the patio, observation revealed no staff were on the patio. The resident sat on the patio in his/her wheelchair from 11:00 A.M. until 11:08 A.M. without staff supervision.

On 1/29/14 at 1:20 P.M. the resident laid in bed. Observation revealed a bed remote within reach of the resident and the resident's call light was not

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within reach. During interview with direct care staff V at that time, he/she stated the remote within the resident's reach operated the height of the the resident's bed. Direct care staff V confirmed the resident's call light was not within his/her reach.

On 1/28/14 at approximately 3:45 P.M. direct care staff CC stated the resident was at risk for falls. Direct care staff CC stated the resident utilized a enabler bar on his/her bed, non-slips strips on his/her bathroom floor and the resident's bed was not a low bed. Direct care staff CC stated the resident should not be left unattended when on the patio.

On 1/30/14 at approximately 8:15 A.M. maintenance staff X stated the resident now received hospice services. When the resident went on hospice service, hospice changed the resident's bed and the resident's bed had the bilateral side rails and not the enabler/handrail. Maintenance staff X stated he/she placed the enabler bar on the resident's bed after the resident transferred from the north to the south hall.

On 1/30/14 at approximately 1:45 P.M. direct care staff S stated staff attempted to not allow the resident to be alone, the resident's bed had an enabler bar, the resident's bed was not a low bed, and staff should supervise the resident when on the patio. Direct care staff S stated the resident utilized a bed and chair alarm at all times and there were a couple of times the resident fell and the alarm did not activate.

On 2/3/14 at approximately 9:00 A.M. licensed nurse K stated the resident's bed was in the

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lowest position, the resident utilized an enabler bar on his/her bed, and the resident could be on the patio without staff supervision.

On 2/3/14 at 11:30 A.M. administrative nursing staff D stated the resident's bed had a enabler bar and staff maintained the resident's bed in the lowest position. Administrative nursing staff stated the resident had quarter side rails and not the enabler bar for a short period of time. Administrative nursing staff stated the resident only required staff supervision when on the patio when he/she smoked.

The facility failed to ensure the resident's bed was in the lowest position, failed to ensure the enabler bar was consistently in place, failed to ensure the resident had his/her call light within reach when in bed, and failed to ensure the resident's bed alarm was not within reach of the resident when in bed as planned for this resident with a history of falls.

- On 1/23/13 at 11:09 A.M. observation revealed 2 space heaters in 2 separate rooms on the south resident hall. Observation revealed one of the space heaters was on and located under a chair in the resident's room. The space heater in another resident's room was approximately 12 inches from furniture in the resident's room.

On 1/23/13 at approximately 3:05 P.M. observation revealed a shared resident room on the north hall had a space heater. Further observation revealed the space heater was 3 to 4 inches away from the resident's bed (bed B).

On 1/29/14 at approximately 11:10 A.M. observation revealed the space heater remained

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in the resident's room on the north hall and was approximately 3 to 4 inches from the resident's bed (bed B). At that time maintenance staff X confirmed the space heater remained in the resident's room.

During interview with maintenance staff X on 1/23/13 at approximately 3:05 P.M. the staff stated he/she did not know the rating of the space heater located in the resident's room on the north hall. Maintenance staff X stated that space heater was different from the other space heaters in residents' room on the south hall and provided the manufacture's information for the space heaters located in the resident's room on the south hall.

The manufacture's information for Compact Ceramic Heaters located in the resident's rooms on the south hall included a Warning that read: "Fire Hazard. Do not use near combustible materials or flammable gases or sources of heat. Keep combustible materials such as furniture, pillows, bedding, papers, clothes and curtains at least 3 feet away from the front of the heater and keep them away from the sides and rear. Do not place a heater near a bed because objects such as pillows or blankets can fall off the bed and be ignited by the heater".

According to guidance from the Centers for Medicare and Medicaid (CMS): The Life Safety Code (LSC) prohibited the use of portable space heating devices in healthcare occupancies except for nonresident and staff sleeping areas with heating elements that exceed 212 degrees. 2000 NFPA (National Fire Prevention Association) 101, 18/19.7.8

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The facility did not provide a policy on space heaters.

The facility failed to ensure space heaters were not used in resident's sleeping areas, failed to ensure the manufactures instructions were followed, and failed to have a policy regarding space heaters.

- On 1/23/13 at approximately 9:15 A.M. observation revealed the employee's bathroom and the resident's bathroom in the basement were unlocked and accessible to residents who attended activities in the basement. At that time the water temperature (obtained from the bathroom sink in the employee's bathroom) was 127 degrees Fahrenheit (F) and the water temperature obtained from the resident's bathroom sink was 127.4 degrees F.

On 1/23/13 at approximately 9:30 A.M. maintenance staff X confirmed the above water temperatures and stated he/she did not check the water temperature in the bathrooms located in the basement.

Review of the facility water temperature logs for 11/21/13, 12/22/13 and 1/22/14 did not include water temperatures located in the resident's or employees bathroom located in the basement of the facility.

The facility's Accident Prevention Policy revised 7/2012 included the facility used a systemic approach to ensure resident's area were safe which included unsafe water temperatures.

The facility failed to maintain safe water

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F 323	Continued From page 70 temperatures in the employee's bathroom in the basement that was unlocked and accessible to residents. The facility also failed to maintain safe water temperatures in the resident's bathroom located in the facility's basement.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 74 residents. The sample included 18 residents. Based on	F 329		

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observation, record review, and staff interview, the facility failed to document behavior monitoring for 4 (#7, #71, #43, #40) of the 6 sampled residents.

Findings included:

- The Physician's Order Sheet (POS) for resident #43, signed 1/2/14, revealed a diagnosis of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods).

The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was cognitively intact. The resident had behaviors not directed toward others, such as hitting or scratching him/herself, pacing, rummaging, public sexual acts, disrobing in public, or screaming.

The Care Area Assessment (CAA) dated 7/18/13 for psychotropic drug use revealed the resident had a long history of mental illness, took psychotropic medication for diagnoses of bipolar disorder with severe psychotic features, and obsessive compulsive disorder (OCD) (an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions sufficiently severe to cause marked distress, consume considerable time or significantly interfere with the patient ' s occupational, social or interpersonal functioning), had no abnormal body movements per the AIMS, the AIMS were completed per policy, had no adverse side effects from long term use of psychotropic medications

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and antidepressant medications were noted, was compliant with his/her medication regimen, and was followed by the psychiatry nurse practitioner and the pharmacy.

The care plan dated 5/8/13 revealed the resident voiced repetitive questions to the point it caused extreme anxiety, exhibited manipulative behaviors and he/she was noncompliant with physician orders. Staff asked if he/she recalled the last response to repetitive questions, informed him/her of behavior expectations, encouraged appropriate behavior, and reminded him/her of nursing expectations when he/she refused physicians orders.

The care plan dated 5/8/13 revealed the resident had a history of hoarding. Nursing staff would inform the physician of increased behaviors.

The care plan dated 5/8/13 revealed the resident voiced repetitive health complaints, and continually sought medical attention. Nursing staff would assess for a factual basis of complaints, monitor and inform the doctor of increases in behaviors.

The care plan dated 5/13/13 with a revision date of 11/12/13 revealed the resident used lexapro and Wellbutrin (antidepressant medications) related to depression, severe bipolar, OCD, and had a potential for side effects. Staff would administer medications as ordered, monitor for side effects and effectiveness of the medications every shift, and monitor for adverse reactions.

Physician's orders reveal medication orders for Wellbutrin 300 milligrams (mg) every morning for

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depression with an order date of 1/8/08, lexapro daily for bipolar with an order date of 10/23/12, and abilify 15 mg at bedtime for bipolar with an order date of 4/9/13.

Undated behavior monitoring forms found behind the October 2013 medication administration record (MAR) in the chart lacked documentation for 15 of 31 evenings and nights on page one. The behaviors listed were obsession, easily distracted, and rambling conversation, and the medications listed were ablilfy and Wellbutrin. Page 2 lacked documentation for 15 of 31 evenings and nights. The behavior listed was manic cleaning and the medications listed were lexapro and Seroquel.

Undated behavior monitoring forms found behind the November 2013 MAR in the chart lacked documentation for 5 of 30 days and 13 of 30 evenings and nights on page one. The behaviors listed were obsessive, easily distracted, and rambling conversation. The medications listed were abilify and Wellbutrin. Page 2 lacked documentation for 5 of 30 days and 13 of 30 evenings and nights. The behavior listed was manic cleaning and the medications were lexapro and Seroquel.

Undated behavior monitoring forms found behind the December 2013 MAR in the chart lacked documentation for 7 of 31 day shifts, 7 of 31 evening shifts, and 8 of 31 night shifts on page one. The behaviors listed were obsessive, easily distracted and rambling conversation. The medications listed were abilify and Wellbutrin. Page 2 lacked documentation on 7 of 31 days, evenings, and nights. The behavior listed was

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manic cleaning and the medications listed were lexapro and Seroquel.

Observation on 1/28/14 at 1:10 P.M. resident was standing in his/her room at the dresser putting a DVD into the player.

Interview on 1/28/14 at 5:00 P.M. with direct care staff V stated the medication aides did behavior charting but he/she would report any violent behavior, harm to self or others, anything out of the normal, or any abnormal behavior for the resident to the nurse.

Interview on 1/29/14 at 1:18 P.M. with direct care staff MM revealed he/she had never seen the resident have behaviors but he/she had confrontations with other residents at times.

Interview on 1/29/14 at 2:57 P.M. with licensed staff I revealed the Certified Medication Aid's (CMA's) did the behavior monitoring forms, and the MDS coordinator made sure they were completed.

Interview on 1/29/14 at 3:36 P.M. with administrative nursing staff D revealed behavior monitor charting was done by the direct care staff and overseen by the nurses, CMA's were expected to know the policy.

The behavior monitoring flow sheet policy dated 6/2008 provided by the facility revealed behaviors would be monitored on those residents receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information

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F 329	Continued From page 75 to members of the interdisciplinary team. The facility failed to identify and effectively monitor for psychotropic medication side effects and behavior monitoring. - The Physician's Order Set (POS) for resident #40, signed 1/2/14 revealed diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), extrapyramidal symptoms (EPS) (movement disorders as a result of taking certain medications), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), Post traumatic stress disorder (PTSD) (psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture), psychosis (any major mental disorder characterized by a gross impairment in reality testing), and borderline personality disorder (disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). The quarterly Minimum Data Set (MDS) dated 11/6/13 revealed the resident had a Brief	F 329		

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Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognitive function. The resident experienced hallucinations, delusions, and rejected evaluation of care.

The Care Area Assessment (CAA) for psychotropic drug use dated 8/6/13 revealed the resident had a long history of mental illness, had delusions, hallucinations, made threats about staff related to diagnoses of schizoaffective disorder, depression, anxiety, delusions, and personality disorder, took psychotropic and antidepressant medications.

The care plan dated 8/13/13 revealed the resident had a history of conflict with staff and verbal and physical aggression. Staff would medicate the resident per the Medication Administration Record (MAR) and document any refusals and monitor for changes in behaviors and increased aggression.

The care plan dated 8/28/13 with revision of 12/23/13 revealed the resident used clonazepam, an antianxiety medication, related to anxiety and schizophrenia and was at risk for side effects. Staff would administer medication as ordered, and monitor for side effects and effectiveness every shift.

The care plan dated 8/28/13 with a revision dated of 12/23/13 revealed the resident received abilify, haldol, Risperdal (psychotropic medications) related to paranoid schizophrenia, personality disorder, depressive disorder, psychosis, delusional disorder, borderline personality disorder, and episodic mood disorder. Staff would administer medications as ordered,

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monitor side effects and effectiveness every shift, and review behaviors and alternate therapies attempted and their effectiveness.

Physician's orders revealed the resident had orders for abilify 40 mg daily with no diagnosis and an order date of 8/1/13, lexapro 20 mg daily for depression with an order date of 8/1/13, clonopin 0.5 mg twice daily for anxiety/schizophrenia with an order date of 8/1/13, cogentin 0.5 mg in A.M. and 1 mg at bedtime with an order date of 1/28/14, haldol 2.5 mg twice daily for delusions with an order date of 8/1/13, and Risperdal 3 mg twice daily for schizophrenia with an order date of 8/1/13.

Behavior monitoring forms dated October 2013 lacked documentation for 16 of 31 evenings and nights on page one. The behaviors listed were obsessing, flat affect, and anxiety. The medications were abilify and clonazepam. Page 2 lacked documentation for 15 of 31 evenings and nights. The behaviors listed were increased agitation and isolating The medications were clonazepam and lexapro. Page 3 lacked documentation for 17 of 31 evenings and nights. The behaviors listed were delusional and paranoia. The medications were haldol and risperidone. Page 4 lacked documentation for 15 of 31 evenings and nights. The behavior listed was mania. The medication was geodon.

Undated behavior monitoring forms found behind the November 2013 MARS lacked documentation for 5 of 30 days and 12 of 30 evenings and nights on page one. The behaviors listed were obsessing, flat affect, and anxiety. The medications were abilify and clonazepam. Page

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2 lacked documentation for 5 of 30 days and 13 of 30 evenings and nights. The behaviors listed were agitation and isolating. The medications were clonazepam and lexapro. Page 3 lacked documentation for 5 of 30 days and 13 of 30 evenings and nights. The behaviors listed were delusional and paranoia. The medications were haldol and risperidone. Page 4 lacked documentation for 5 of 30 days and 13 of 30 evenings and nights. The behavior listed was mania. The medication was geodon.

Undated behavior monitoring forms found behind the December 2013 MARS lacked documentation for 7 of 31 days, evenings, and nights on page one. The behaviors listed were obsessing, flat affect, and anxiety. The medications were abilify and clonazepam. Page 2 lacked documentation for 7 of 31 days, evenings, and nights. The behaviors listed were agitation and isolating. The medications were clonazepam and lexapro. Page 3 lacked documentation for 7 of 31 days, evenings, and nights. The behaviors listed were delusional and paranoia and the medications were haldol and risperidone. Page 4 lacked documentation for 7 of 31 days, evenings, and nights. The behaviors was mania and the medication was geodon.

Behavior monitoring forms dated January 2014 lacked documentation for 1 of 29 evening and night shifts on page one. The behaviors listed were anxiety and staff seeking. The medications were abilify and clonazepam. Page 2 had consistent documentation. The behaviors were agitation and isolating. The medications were clonazepam and lexapro. Page 3 had consistent documentation. The behaviors listed were delusions, paranoid, and verbal aggression. The

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medications were haldol and risperidone. Page 4 had consistent documentation. The behaviors listed were mania and physical aggression and the medication was geodon.

Observation on 1/28/14 at 1:05 P.M. resident was standing in the hall by the dining room greeting peers as they walked by.

An interview on 1/28/14 at 5:00 P.M. with direct care staff V revealed the medication aides did behavior charting and would report anything abnormal to the nurse.

An interview on 1/29/14 at 2:16 P.M. with direct care staff U revealed the resident had mood swings but was never violent. The nurse or medication aide did behavior charting.

Interview on 1/29/14 at 2:40 P.M. with licensed staff I revealed the resident had delusions, a flat affect, and self isolated, certified Medication Aide's (CMA's) did the behavior monitoring forms, and the MDS coordinator made sure they were completed.

Interview on 1/29/14 at 3:36 P.M. with administrative nursing staff D revealed behavior monitor charting was done by the direct care staff and over seen by the nurses, and medication aides were expected to know the policy for behavior monitoring.

The behavior monitoring flow sheet policy dated 6/2008 provided by the facility revealed behaviors would be monitored on those residents receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information

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F 329	Continued From page 80 to members of the interdisciplinary team. The facility failed to complete behavior monitoring for this resident who received psychoactive medications. - The signed physician order set (POS) dated 12/31/13 revealed resident #7 had diagnoses of Bipolar (recurrent moods of both mania and depression), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness. The Quarterly Minimum Data Set (MDS) dated 1/10/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact, he/she took antipsychotic, antianxiety and antidepressant medications. The Care Area Assessment (CAA) dated 10/11/13 revealed the resident took antipsychotics and anti-depressants for history of mental illness. The resident's medications did not present a problem, he/she was aware of his/her	F 329		

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mental illness and stated the medicine helped.

The revised care plan dated 11/11/13 revealed the resident had history of medication non-compliance, and nursing staff was to monitor the resident for changes in mood and/or behavior, notify the clinical team, and report medication non-compliance.

Review of the POS dated 12/31/13 revealed the resident received the following medications:
7/26/11 Divalproex sodium (Depakote) 500 mg tablet by mouth every morning for bipolar.
7/26/11 Divalproex sodium (Depakote) 250 mg tablet by mouth every morning for bipolar.
7/26/11 Divalproex sodium (Depakote) 500 mg tablet take 2 tablets (1000 mg total dose) by mouth at bedtime for bipolar.
3/1/13 Escitalppram Oxalate (lexapro) 10 mg tablet by mouth every day for depression.
10/2/13 Seroquel XR 150 mg tablet by mouth every morning for delusions/paranoia.
1/28/13 Quetiapine Fumarate (Seroquel) 200 mg tablet by mouth at bedtime for bipolar/manic.
12/21/12 cymbalta 60 mg capsule by mouth twice daily for bipolar.
4/30/13 risperidone (Risperdal) 4 mg tablet by mouth twice daily for schizophrenia.
10/3/13 Diazepam (Valium) 2 mg tablet by mouth three times daily.
6/18/13 Diazepam (Valium) 5 mg tablet give 1 1/2 (7.5 mg total dose) by mouth twice daily as needed for anxiety/agitation.

On 1/29/14 record review of the undated psychoactive drug monthly flow record in the current behavior book revealed the sheet for escitalopram listed behaviors of isolation lacked documentation for 12 shifts, and rambling

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conversations lacked documentation for 12 shifts. The behavior sheet for quetiapine fumarate and risperidone listed behaviors of hallucinations lacked documentation for 9 shifts in 27 days and behavior of manic lacked documentation for 6 of 27 days. The behavior sheet for Seroquel with the behavior of delusional episodes lacked documentation for 12 shifts in 27 days and the behavior paranoia lacked documentation for 9 shifts in 27 days.

On 1/29/14 record review of the undated Psychoactive drug monthly flow record lacked consistent documentation.

On 1/29/14 at 9:54 A.M. the resident was standing in the hall talking calmly with direct care staff LL.

On 1/29/14 at 10:29 A.M. direct care staff LL stated behaviors were documented on the behavior sheet in the behavior book and would tell the charge nurse if he/she noticed any abnormal behaviors for the resident.

On 1/29/14 at 10:30 A.M. direct care staff V stated the resident's behaviors were documented on the psychoactive drug monthly record, that he/she would tell the charge nurse if the resident displayed abnormal behaviors.

On 1/29/14 at 4:09 P.M. license staff I stated the resident's behaviors were monitored by observation.

On 1/30/14 at 11:29 A.M. administrative nursing staff D stated the resident's behavior monitor sheets were expected to be filled out completely

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by the medication aides and the charge nurse would check for completeness every shift before medication aides could leave, and they were spot checked by the Director of Nursing, Assistant Director of Nursing, and MDS Coordinator for completion.

On 2/3/14 at 11:47 A.M. administrative staff C stated he/she expected staff to fill out resident behavior forms completely.

The facility policy for behavior monitoring Flow Sheet dated 2008 revealed the resident's behaviors would be monitored on resident's receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information to member of the interdisciplinary team. Medication aides and License Mental Health Technicians would document all behaviors experienced or expressed by the residents at the end of each shift, and report to the charge nurse when finished documentation and when behaviors were excessive, out of control or new for the resident. The charge nurse would consult the director of Nursing or social worker to determine if further documentation or monitoring was necessary. If further documentation or monitoring was necessary it would be noted on the 24 hours report and in Acute Charting.

The facility failed to consistently document behaviors for this resident.

- The signed physician order sheet (POS) dated 12/28/13 revealed resident #71 had diagnoses of

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schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction), major depressive disorder with recurrent episodes, and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly Minimum Data Set (MDS) dated 12/20/13 revealed the resident had a Brief Interview for Mental Status (BIMS) of 11 which indicated the resident had moderately impaired cognition, received antipsychotic, anti-anxiety, antidepressant, and hypnotic medications.

The Care Area Assessment (CAA) dated 7/11/13 revealed the resident received psychotropic medications had a schizoaffective disorder with psychiatric medications. He/she was compliant with medications and had Seroquel (an anti-psychotic medication) scheduled per the medication administration record (MAR).

The revised Care Plan dated 1/23/14 revealed the resident had anger and verbal aggression interventions including the nursing staff would medicate the resident per physician orders and would document and inform the physician and the treatment team of any medication refusals. Administer antidepressant medications as ordered by doctor, monitor document and report adverse reactions to antidepressant treatment which included change in the resident's behavior/mood/cognition hallucinations, delusions, social isolation, suicidal thoughts, and withdrawal,

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Review of the POS dated 12/28/13 revealed the resident received the following medications:
escatalopram oxalate (lexapro) 20 mg by mouth every morning for depression.
8/13/13 Seroquel XR 200 mg by mouth every morning.
11/19/13 Lorazepam (Ativan) 1 mg by mouth every day at 1900 for anxiety.
12/10/13 Lamotrigine (Lamictal) 150 mg tablet by mouth twice daily for mood disorder/bipolar.
12/10/13 Ziprasidone HCL (Geodon) 400 mg capsule by mouth every morning and every evening with super for schizoaffective disorder.
11/26/13 Citalapram (celexa) 20 mg tablet give 1 and 1/2 tablets (30 mg total dose) by mouth at bedtime for schizoaffective disorder/depression.
7/9/13 Fanapt 12 mg tablet by mouth at bedtime for schizoaffective disorder.
7/1/13 Loxapine 25 mg capsule give 3 capsule (75 mg total dose) at bedtime for mania.
6/17/13 Quetiapine furarate (Seroquel) 300 mg tablet give 2 tablets (600 mg total dose) by mouth at bedtime for schizoaffective.

The signed POS dated 12/28/13 lacked documentation for parameters for blood pressures.

The undated psychoactive drug monthly flow record found in the current behavior book lacked documentation for 12 shifts in 27 days and revealed the sheet for alprazolam and citalopram behaviors of isolation 9 days out of 27, and drug seeking 18 times in 27 days. The sheet for escitalopram and fanapt lacked documentation for 12 shifts in 27 days with behaviors of tearful and slamming doors never happened in 27 days. The sheet for lorazepam, loxapine and

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olanzapine lacked documentation for 12 shifts in 27 days with behaviors listed as delusions and paranoia never happened in 27 days. The sheet for Seroquel lacked documentation for 12 shifts in 27 days and listed behavior of manic never happened in 27 days. The sheet for ziprasidone and zolpidem lacked documentation for 12 shifts in 27 days listed behaviors of insomnia never happened in 27 days.

The undated Psychoactive drug monthly flow record found behind the December and November Medication Administration Record (MAR)s lacked consistent documentation as above.

1/28/14 at 2:30 P.M. The resident was sitting on edge of bed, alert, calm.

On 1/29/14 at 10:29 A.M. direct care staff LL stated behaviors were documented on the behavior sheet in the behavior book.

On 1/29/14 at 10:30 A.M. direct care staff V stated the resident's behaviors were documented on the psychoactive drug monthly record.

2/3/14 11:55 A.M. direct care staff LL felt he/she knew the resident well and would report abnormal behavior to the charge nurse.

1/30/14 at 11:29 A.M. administrative nursing staff D expected the medication aides to fill out the

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F 329	Continued From page 87 residents' behavior monitoring sheets every shift and the charge nurse over sees the documentation to ensure it was complete before the medication aides left, and the behavior monitoring sheets were spot checked for completion. On 2/3/14 at 11:47 A.M. administrative staff C stated he/she expect staff to fill out resident behavior forms completely. The facility policy for behavior monitoring Flow Sheet dated 2008 revealed the resident's behaviors would be monitored on resident's receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information to member of the interdisciplinary team. Medication aides and License Mental Health Technicians would document all behaviors experienced or expressed by the residents at the end of each shift, and report to the charge nurse when finished documentation and when behaviors were excessive, out of control or new for the resident. The charge nurse would consult the director of Nursing or social worker to determine if further documentation or monitoring was necessary. If further documentation or monitoring was necessary it would be noted on the 24 hours report and in Acute Charting. The facility failed to consistently document behaviors for this resident who received psychoactive medications.	F 329		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	F 354		

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F 354	Continued From page 88 Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility reported a census 74 residents. Based on record review and interview the facility failed to staff a registered nurse (RN) for at least eight consecutive hours a day, seven days a week for three out of 60 days reviewed. Findings included: - On 2/3/14 at 10:15 A.M. review of staffing time clock schedules for 1/9/14, 1/29/14 and 1/30/14 revealed there was no RN on duty for the 24 hour period. On 2/3/14 at 10:17 A.M. office staff B stated there was no RN coverage on 1/9/14, 1/29/14 and 1/30/14. On 2/3/14 at 10:38 A.M. Administrative nursing staff D stated it was expected to have 8 hours of continuous RN coverage in a 24 hours period.	F 354		

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F 354	Continued From page 89 The facility failed to have 8 consecutive hours of RN staff for 3 out of 60 days reviewed.	F 354		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356		

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The facility reported a census 74 residents. Based on observation, record review and interview the facility failed to post current nurse staffing information three of six days on-site.

Findings included:

- On 1/30/14 at 4:08 P.M. the staffing/Full Time Equivalents (FTE) were posted by the back door at approximately 5 feet from the floor, not accessible to everyone. Hours were dated 1/27/14, 1/28/14 and 1/28/14. There was no posting dated for 1/29/14.

On 2/3/14 at 7:30 A.M. review of the posted FTE lacked documentation for 1/31/14, 2/1/14, 2/2/14 and 2/3/14.

On 2/3/14 at 8:22 A.M. random review of the FTE forms dated 10/21/13 lacked documentation for licensed nursing staff from 10:00 P.M. to 6:00 A.M., review of the FTE dated 11/4/13 lacked licensed nursing staff from 10:00 P.M. to 6:00 A.M., of the FTE dated 11/18/13 the Nursing staffing hours form lacked licensed nursing staff from 7:00 P.M. to 7:00 A.M. and lacked documentation of licensed mental health technician (LMHT) or Certified Medication Aide (CMA) from 10:00 P.M. to 6:00 A.M., review of the FTE dated 12/3/13 Nursing staffing hours form lacked documentation for LMHT or CMA from 10:00 P.M. to 6:00 A.M., review of the FTE dated 1/2/14 nursing staffing hours lacked documentation for LMHT or CMA from 2-10 P.M..

On 2/3/14 at 8:22 A.M. review of the untitled nursing staffing log dated 1/7/14-1/11/14 lacked documentation for completeness and was not filled out on 1/10/14.

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F 356	Continued From page 91 On 2/3/14 at 8:40 A.M. administrative staff D stated the night nurse was responsible for filling out and posting the FTE. The old FTEs were to be kept in the medical records and the assistance director of nursing was looking for more daily staffing postings. On 2/3/14 at approximately 8:45 A.M. the facility lacked documentation on total number and actual hours worked for Registered Nurse (RN's), Licensed Practical Nurse (LPN's), Certified Nurse Aide (CNA's) and resident census and failed to maintain the posted daily nurse staffing data for the last 18 months (the facility provided documentation for the following dates: 10/21/13, 11/4/13,11/18/13, 12/3/13, 1/2/14, 1/7/14, 1/8/14, 1/9/14, 1/10/14, 1/11/14, 1/27/14, 1/28/14,1/30/14 and 2/3/14). The facility failed to post current FTEs for 3 of 6 observation days of the survey and failed to keep FTE records for the last 18 months.	F 356		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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by:
The facility identified a census of 74 residents. Based on observation and staff interview, the facility failed to properly sanitize dining tables in 1 of 1 dining room on 2 of 6 days on site of survey.

Findings included:

- During an observation on 1/23/14 at 11:46 A.M. staff wiped tables with cloths kept in a sanitizing bucket. Residents immediately received trays before tables were dry.

Observation on 1/29/14 at 11:50 A.M. staff wiped tables with cloths kept in a sanitizing bucket. Residents immediately received trays before tables were dry.

Interview on 1/29/14 at 11:10 A.M. dietary staff DD stated bleach and sanitizer tablets were in the sanitizing bucket to clean and sanitize the tables. He/she was unsure of the dry time.

Review of the manufacturer's instructions on 1/29/14 at 11:10 A.M. bleach had a dry time of 2 minutes and the sanitizer tablets had a dry time of one minute.

On 1/30/14 at 7:43 A.M. with dietary staff EE stated he/she was unaware of the dry time for these chemicals and realized that residents received their trays before the table was dry.

The facility failed to provide a policy and procedure for sanitizing of the dining area.

The facility failed to sanitize dining tables according to manufacturer's guidelines.

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F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	F 406		

If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 74 residents. The sample included 18 residents. Based upon observation, record review and interview the facility failed to ensure that 1 (#27) of 1 residents received specialized rehabilitative services by qualified personnel in a timely manner.

Findings included:

- Resident #27's admission Minimum Data Set (MDS) dated 12/6/13 included the resident was admitted to the facility on 11/29/13, scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status, scored 13 (moderate depression-mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or longer) on the 9-Item Patient Health Questionnaire. The MDS identified the resident had hallucinations (sensed things that appear to be real), delusions (false beliefs), and did not have behaviors. The MDS recorded the resident was independent with bed

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mobility, required extensive staff assistance with transfers, dressing, toilet use and personal hygiene.

The resident's Mood CAA dated 12/12/13 documented the resident was readmitted to the facility for the 3rd time on 11/29/13 after a stay at a local inpatient psychiatric hospital. The resident was not stable since admission, had confusion, poor tracking in interactions, increased neediness, and some aggression.

The resident's care plan dated 12/27/13 included the resident frequently sought staff attention/time, staff encouraged him/her to write down issues he/she wanted to discuss and the resident approached 1 staff with the list. Staff provided positive verbal praise when the resident appropriately utilized the staff time and did not readdress issues repeatedly. The resident exhibited anger and both verbal and physical aggression since this admission, and some of this was to his/her confusion/disorientation. The care plan included on 12/31/13 the resident struck 2 staff members, if the resident continued to escalate in aggression either physically or verbally and staff was unable to diffuse social services would set up a crisis screen, if the physician, ordered to assess the resident for need of greater supports.

The resident's PASRR (Pre-Admission Screening and Resident Review) dated 11/27/13 included the resident would benefit from education in anger management and working toward demonstrating an understanding of appropriate socialization action both in the nursing home environment as well as without the environment on any outing, etc. The resident would benefit

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from working with any available mental health supportive services to deal with PTSD and/or specialized services to assist with possible traumatic brain injury (TBI-brain injury). If the nursing facility cannot provide these services the nursing home would need to contract for those services.

A physician's Admission Summary dated 12/11/13 and timed 4:28 P.M. documented on admission the resident was very confused, more aggressive in responses about what he/she wanted, struggled daily since admission, was not eating well, and had periods of verbal aggression.

A physician's order dated 1/8/14 and not timed included for the resident to receive psychotherapy due to past grief and loss.

The resident's clinical record revealed an Advanced Registered Nurse Practitioner (ARNP) saw the resident on 12/3/13, 1/7/14 and on 1/14/14 for medication management. The resident's clinical record did not support the ARNP provided specialized services that addressed TBI or PTSD.

A diagnostic evaluation from a behavioral entity dated 1/22/14 (approximately two months after the resident was admitted to the facility) documented the reason for the referral was to address the resident's grief and loss. The resident was readmitted to this facility after he/she was discharged to a supported apartment living entity about 10 months prior. Recommendations included a structured living environment and initiation of individualized psychotherapy every two weeks to address loss, grief, and anxiety.

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The facility's wellness group log from 12/2013 to 1/2014 did not support the resident attended the wellness groups.

On 1/29/14 at 7:05 A.M. direct care staff S and licensed social service staff J were in the resident's room, the resident laid in bed, and the resident stated he/she had a nightmare last night.

On 1/28/14 at approximately 1:00 P.M. direct care staff V stated he/she conducted the facility's wellness groups on Wednesday and Thursday of each week. Direct care staff V stated the wellness group encompassed a variety of things including anger management but was not individualized.

On 1/28/14 at 3:02 P.M. social service staff KK stated the ARNP provided medication management and not psychotherapy. Social service staff KK stated the resident saw a behavioral entity on 1/22/14 that provided psychotherapy. Social service staff KK said the resident did not receive psychotherapy regarding grief and loss until 1/22/14.

On 1/28/14 licensed social service staff J stated he/she sent a facsimile to the behavioral entity on 1/13/14 at 8:09 A.M. regarding the referral for the resident to receive psychotherapy for grief and loss.

The facility's undated Psychotherapy Policy did not address how the facility obtained specialized rehabilitation services to ensure residents received the necessary services outlined in the PASRR.

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F 406	Continued From page 97 The facility failed to ensure this resident received specialized rehabilitation services as planned in a timely manner.	F 406		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 74 residents. The sample included 18 residents. Based on observation, record review, and staff interview, the facility's consulting pharmacist failed to identify and report the irregularity of inconsistent behavior monitoring to the facility for 3 (#7, #71, #43) of the 6 sampled residents. Findings included: - The Physician's Order Sheet (POS) for resident #43, signed 1/2/14, revealed a diagnosis of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The quarterly Minimum Data Set (MDS) with an	F 428		

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Assessment Reference Date (ARD) of 10/18/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was cognitively intact. The resident had behaviors not directed toward others, such as hitting or scratching him/herself, pacing, rummaging, public sexual acts, disrobing in public, or screaming.

The Care Area Assessment (CAA) dated 7/18/13 for psychotropic drug use revealed the resident had a long history of mental illness, took psychotropic medication for diagnoses of bipolar disorder with severe psychotic features, and obsessive compulsive disorder (OCD) (an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions sufficiently severe to cause marked distress, consume considerable time or significantly interfere with the patient ' s occupational, social or interpersonal functioning), had no abnormal body movements per the AIMS, the AIMS were completed per policy, had no adverse side effects from long term use of psychotropic medications and antidepressant medications were noted, was compliant with his/her medication regimen, and was followed by the psychiatry nurse practitioner and the pharmacy.

The care plan dated 5/8/13 revealed the resident voiced repetitive questions to the point it caused extreme anxiety, exhibited manipulative behaviors and he/she was noncompliant with physician orders. Staff asked if he/she recalled the last response to repetitive questions, informed him/her of behavior expectations, encouraged appropriate behavior, and reminded him/her of nursing expectations when he/she refused physicians orders.

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The care plan dated 5/8/13 revealed the resident had a history of hoarding. Nursing staff would inform the physician of increased behaviors.

The care plan dated 5/8/13 revealed the resident voiced repetitive health complaints, and continually sought medical attention. Nursing staff would assess for a factual basis of complaints, monitor and inform the doctor of increases in behaviors.

The care plan dated 5/13/13 with a revision date of 11/12/13 revealed the resident used lexapro and Wellbutrin (antidepressant medications) related to depression, severe bipolar, OCD, and had a potential for side effects. Staff would administer medications as ordered, monitor for side effects and effectiveness of the medications every shift, and monitor for adverse reactions.

Physician's orders reveal medication orders for Wellbutrin 300 milligrams (mg) every morning for depression with an order date of 1/8/08, lexapro daily for bipolar with an order date of 10/23/12, and abilify 15 mg at bedtime for bipolar with an order date of 4/9/13.

Undated behavior monitoring forms found behind the October 2013 medication administration record (MAR) in the chart lacked documentation for 15 of 31 evenings and nights on page one. The behaviors listed were obsession, easily distracted, and rambling conversation, and the medications listed were ablilfy and Wellbutrin. Page 2 lacked documentation for 15 of 31 evenings and nights. The behavior listed was

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manic cleaning and the medications listed were lexapro and Seroquel.

Undated behavior monitoring forms found behind the November 2013 MAR in the chart lacked documentation for 5 of 30 days and 13 of 30 evenings and nights on page one. The behaviors listed were obsessive, easily distracted, and rambling conversation. The medications listed were abilify and Wellbutrin. Page 2 lacked documentation for 5 of 30 days and 13 of 30 evenings and nights. The behavior listed was manic cleaning and the medications were lexapro and Seroquel.

Undated behavior monitoring forms found behind the December 2013 MAR in the chart lacked documentation for 7 of 31 day shifts, 7 of 31 evening shifts, and 8 of 31 night shifts on page one. The behaviors listed were obsessive, easily distracted and rambling conversation. The medications listed were abilify and Wellbutrin. Page 2 lacked documentation on 7 of 31 days, evenings, and nights. The behavior listed was manic cleaning and the medications listed were lexapro and Seroquel.

The monthly Drug Regimen Reviews done from 10/24/12 to 1/15/14 failed to recognize the facility failed to consistently monitor behaviors.

Observation on 1/28/14 at 1:10 P.M. resident was standing in his/her room at the dresser putting a DVD into the player.

Interview on 1/28/14 at 5:00 P.M. with direct care staff V stated the medication aides did behavior charting but he/she would report any violent

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behavior, harm to self or others, anything out of the normal, or any abnormal behavior for the resident to the nurse.

Interview on 1/29/14 at 1:18 P.M. with direct care staff MM revealed he/she had never seen the resident have behaviors but he/she had confrontations with other residents at times.

Interview on 1/29/14 at 2:57 P.M. with licensed staff I revealed the Certified Medication Aid's (CMA's) did the behavior monitoring forms, and the MDS coordinator made sure they were completed.

Interview on 1/29/14 at 3:36 P.M. with administrative nursing staff D revealed behavior monitor charting was done by the direct care staff and overseen by the nurses, CMA's were expected to know the policy.

Interview on 2/3/14 at 1:43 P.M. interview with pharmacy consultant staff F revealed he/she would expect behaviors to be monitored and documented on the behavior sheets.

The behavior monitoring flow sheet policy dated 6/2008 provided by the facility revealed behaviors would be monitored on those residents receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information to members of the interdisciplinary team.

The facility's consulting pharmacist failed to identify and report the irregularity of inconsistent behavior monitoring to the facility this resident

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F 428	Continued From page 102 who received psychotropic medications. - The signed physician order set (POS) dated 12/31/13 revealed resident #7 had diagnoses of Bipolar (recurrent moods of both mania and depression), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness. The Quarterly Minimum Data Set (MDS) dated 1/10/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact, he/she took antipsychotic, antianxiety and antidepressant medications. The Care Area Assessment (CAA) dated 10/11/13 revealed the resident took antipsychotics and anti-depressants for history of mental illness. The resident's medications did not present a problem, he/she was aware of his/her mental illness and stated the medicine helped. The revised care plan dated 11/11/13 revealed the resident had history of medication non-compliance, and nursing staff was to monitor the resident for changes in mood and/or behavior, notify the clinical team, and report medication non-compliance. Review of the POS dated 12/31/13 revealed the resident received the following medications: 7/26/11 Divalproex sodium (Depakote) 500 mg	F 428		

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tablet by mouth every morning for bipolar.
7/26/11 Divalproex sodium (Depakote) 250 mg tablet by mouth every morning for bipolar.
7/26/11 Divalproex sodium (Depakote) 500 mg tablet take 2 tablets (1000 mg total dose) by mouth at bedtime for bipolar.
3/1/13 Escitalppram Oxalate (lexapro) 10 mg tablet by mouth every day for depression.
10/2/13 Seroquel XR 150 mg tablet by mouth every morning for delusions/paranoia.
1/28/13 Quetiapine Fumarate (Seroquel) 200 mg tablet by mouth at bedtime for bipolar/manic.
12/21/12 cymbalta 60 mg capsule by mouth twice daily for bipolar.
4/30/13 risperidone (Risperdal) 4 mg tablet by mouth twice daily for schizophrenia.
10/3/13 Diazepam (Valium) 2 mg tablet by mouth three times daily.
6/18/13 Diazepam (Valium) 5 mg tablet give 1 1/2 (7.5 mg total dose) by mouth twice daily as needed for anxiety/agitation.

On 1/29/14 record review of the undated psychoactive drug monthly flow record in the current behavior book revealed the sheet for escitalopram listed behaviors of isolation lacked documentation for 12 shifts, and rambling conversations lacked documentation for 12 shifts. The behavior sheet for quetiapine fumarate and risperidone listed behaviors of hallucinations lacked documentation for 9 shifts in 27 days and behavior of manic lacked documentation for 6 of 27 days. The behavior sheet for Seroquel with the behavior of delusional episodes lacked documentation for 12 shifts in 27 days and the behavior paranoia lacked documentation for 9 shifts in 27 days.

On 1/29/14 record review of the undated

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F 428	Continued From page 104 Psychoactive drug monthly flow record lacked consistent documentation. The monthly Drug Regimen Review from 1/17/13 to 1/15/14 revealed the pharmacist failed to identify the facilities failures to consistently monitor behaviors. On 1/29/14 at 9:54 A.M. the resident was standing in the hall talking calmly with direct care staff LL. On 1/29/14 at 10:29 A.M. direct care staff LL stated behaviors were documented on the behavior sheet in the behavior book and would tell the charge nurse if he/she noticed any abnormal behaviors for the resident. On 1/29/14 at 10:30 A.M. direct care staff V stated the resident's behaviors were documented on the psychoactive drug monthly record, that he/she would tell the charge nurse if the resident displayed abnormal behaviors. On 1/29/14 at 4:09 P.M. license staff I stated the resident's behaviors were monitored by observation. On 1/30/14 at 11:29 A.M. administrative nursing staff D stated the resident's behavior monitor sheets were expected to be filled out completely by the medication aides and the charge nurse would check for completeness every shift before medication aides could leave, and they were spot checked by the Director of Nursing, Assistant Director of Nursing, and MDS Coordinator for completion.	F 428		

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F 428	Continued From page 105 On 2/3/14 at 1:43 P.M. pharmacist consultant F stated he/she would expect behaviors be monitored and documented on the behavior sheets. On 2/3/14 at 11:47 A.M. administrative staff C stated he/she expected staff to fill out resident behavior forms completely. The facility policy for behavior monitoring Flow Sheet dated 2008 revealed the resident's behaviors would be monitored on resident's receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information to member of the interdisciplinary team. Medication aides and License Mental Health Technicians would document all behaviors experienced or expressed by the residents at the end of each shift, and report to the charge nurse when finished documentation and when behaviors were excessive, out of control or new for the resident. The charge nurse would consult the director of Nursing or social worker to determine if further documentation or monitoring was necessary. If further documentation or monitoring was necessary it would be noted on the 24 hours report and in Acute Charting. The facility's consulting pharmacist failed to identify and report the irregularity of inconsistent behavior monitoring to the facility this resident who received psychotropic medications.	F 428		

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F 428	Continued From page 106 - The signed physician order sheet (POS) dated 12/28/13 revealed resident #71 had diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction), major depressive disorder with recurrent episodes, and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The quarterly Minimum Data Set (MDS) dated 12/20/13 revealed the resident had a Brief Interview for Mental Status (BIMS) of 11 which indicated the resident had moderately impaired cognition, received antipsychotic, anti-anxiety, antidepressant, and hypnotic medications. The Care Area Assessment (CAA) dated 7/11/13 revealed the resident received psychotropic medications had a schizoaffective disorder with psychiatric medications. He/she was compliant with medications and had Seroquel (an anti-psychotic medication) scheduled per the medication administration record (MAR). The revised Care Plan dated 1/23/14 revealed the resident had anger and verbal aggression interventions including the nursing staff would medicate the resident per physician orders and would document and inform the physician and the treatment team of any medication refusals. Administer antidepressant medications as ordered by doctor, monitor document and report adverse reactions to antidepressant treatment which included change in the resident's behavior/mood/cognition hallucinations, delusions, social isolation, suicidal thoughts, and withdrawal,	F 428		

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Review of the POS dated 12/28/13 revealed the resident received the following medications:
escatalopram oxalate (lexapro) 20 mg by mouth every morning for depression.
8/13/13 Seroquel XR 200 mg by mouth every morning.
11/19/13 Lorazepam (Ativan) 1 mg by mouth every day at 1900 for anxiety.
12/10/13 Lamotrigine (Lamictal) 150 mg tablet by mouth twice daily for mood disorder/bipolar.
12/10/13 Ziprasidone HCL (Geodon) 400 mg capsule by mouth every morning and every evening with super for schizoaffective disorder.
11/26/13 Citalapram (celexa) 20 mg tablet give 1 and 1/2 tablets (30 mg total dose) by mouth at bedtime for schizoaffective disorder/depression.
7/9/13 Fanapt 12 mg tablet by mouth at bedtime for schizoaffective disorder.
7/1/13 Loxapine 25 mg capsule give 3 capsule (75 mg total dose) at bedtime for mania.
6/17/13 Quetiapine furarate (Seroquel) 300 mg tablet give 2 tablets (600 mg total dose) by mouth at bedtime for schizoaffective.

The undated psychoactive drug monthly flow record found in the current behavior book lacked documentation for 12 shifts in 27 days and revealed the sheet for alprazolam and citalopram behaviors of isolation 9 days out of 27, and drug seeking 18 times in 27 days. The sheet for escitalopram and fanapt lacked documentation for 12 shifts in 27 days with behaviors of tearful and slamming doors never happened in 27 days. The sheet for lorazepam, loxapine and olanzapine lacked documentation for 12 shifts in 27 days with behaviors listed as delusions and

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paranoia never happened in 27 days. The sheet for Seroquel lacked documentation for 12 shifts in 27 days and listed behavior of manic never happened in 27 days. The sheet for ziprasidone and zolpidem lacked documentation for 12 shifts in 27 days listed behaviors of insomnia never happened in 27 days.

The undated Psychoactive drug monthly flow record found behind the December and November Medication Administration Record (MAR)s lacked consistent documentation as above.

Review of the monthly Drug Regimen Review from 6/23/13 to 1/15/14 revealed the pharmcist failed to recognize the facility's failure to consistently monitor behaviors.

1/28/14 at 2:30 P.M. The resident was sitting on edge of bed, alert, calm.

On 1/29/14 at 10:29 A.M. direct care staff LL stated behaviors were documented on the behavior sheet in the behavior book.

On 1/29/14 at 10:30 A.M. direct care staff V stated the resident's behaviors were documented on the psychoactive drug monthly record.

2/3/14 11:55 A.M. direct care staff LL felt he/she knew the resident well and would report abnormal behavior to the charge nurse.

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1/30/14 at 11:29 A.M. administrative nursing staff D expected the medication aides to fill out the residents' behavior monitoring sheets every shift and the charge nurse over sees the documentation to ensure it was complete before the medication aides left, and the behavior monitoring sheets were spot checked for completion.

On 2/3/14 at 1:43 P.M. pharmacist consultant F stated he/she would expect behaviors be monitored and documented on the behavior sheets.

On 2/3/14 at 11:47 A.M. administrative staff C stated he/she expect staff to fill out resident behavior forms completely.

The facility policy for behavior monitoring Flow Sheet dated 2008 revealed the resident's behaviors would be monitored on resident's receiving psychiatric medications in order to evaluate the ongoing benefits and provide valuable information to member of the interdisciplinary team. Medication aides and License Mental Health Technicians would document all behaviors experienced or expressed by the residents at the end of each shift, and report to the charge nurse when finished documentation and when behaviors were excessive, out of control or new for the resident. The charge nurse would consult the director of Nursing or social worker to determine if further documentation or monitoring was necessary. If further documentation or monitoring was

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F 428	Continued From page 110 necessary it would be noted on the 24 hours report and in Acute Charting. The facility's consulting pharmacist failed to identify and report the irregularity of inconsistent behavior monitoring to the facility this resident who received psychotropic medications.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		

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package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 74 residents. Based upon observation, record review and interview the facility failed to ensure expired medications were not located in the medication cart for 1 of 2 medication carts observed.

Findings included:

- During the initial tour on 1/23/14 at approximately 9:15 A.M. observation of the medication cart on the south hall revealed a bubble pack that contained (56) 0.5 milligrams (mg) of Lorazepam (an anti-anxiety medication) with an expiration date of 1/14/14.

A bubble pack that contained (30) 1.0 mg of Clonazepam (an anxiety) with an expiration date of 1/1/14.

A bubble pack that contained (20) 0.5 mg of Alprazolam (an anti-anxiety) with an expiration date of 11/25/13 and a bubble pack that contained (6) Isomethept (used to treat migraines and tension headaches) with an expiration date of 1/18/14.

A bubble pack that contained (22) 10 mg of Zaleplon (a sedative-hypnotic) with an expiration date of 12/14/13.

On 1/23/14 at the time of each finding, beginning

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F 431	Continued From page 112 at approximately 9:15 A.M. direct care staff NN (staff who administered medications) confirmed the quantity and expiration dates. The facility's Medication Administration Policy revised 8/2012 included residents would receive medications according to established policies, regulations and physician orders. The facility failed to ensure expired medications were removed from the medication cart and not available for resident use/	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 74 residents. Based upon observation, record review and interviews the facility failed to have an effective infection control program that prevented, recognized and controlled the spread of infection for the residents in the facility.

Findings included:

- On 1/27/14 at 7:54 A.M. direct care staff PP administered medications to resident #24. Observation revealed direct care staff handed resident #24 an Advair Diskus (a dry powder inhaler) and the resident placed the device in his/her mouth. Further observation revealed the name on the inhaler was not the resident's. Direct care staff PP then informed resident #24 the inhaler was not his/hers after looking at the label and the resident handed the inhaler to direct care staff. Direct care staff PP placed the inhaler back into the container and did not wash/sanitize the inhaler.

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Review of the facility infection control logs from August 2013 to December 2013 revealed there was not a completed infection control log for November 2013. Review of the facility's December 2013 infection control log revealed the log did not include the name of organisms under the organism column. The log contained a Y for yes or a N for no. The log did not include whether infections were community or facility acquired. The log did not include the date the infection was resolved. Comparing the facility's log to the antibiotic usage report received from a pharmacy revealed all antibiotics residents received during the month of December 2013 were not included on the facility's log. For example Azithromycin a " Z-pack" (an antibiotic used to treat bacterial infections) received by 1 resident for 5 days during the month of December was not included on the log. Another resident received Cefuroxime (an antibiotic) 250 milligrams (mg) twice a day for 5 days (start date of 12/28/13) and it was not included on the facility's log. Another resident received 50 mg of Macrodantin (an antibiotic used to treat urinary tract infections) with a last fill date of 12/16/13 and was not included on the facility's infection control log.

On 1/28/14 at 5:00 P.M. administrative nursing staff D stated the facility changed labs and the old lab did not send the facility the antibiotic usage report for November 2013; therefore he/she did not complete an infection control log for the month of November 2013.

On 1/29/14 at approximately 8:40 A.M. housekeeping staff Y cleaned a resident's room on the south hall. Housekeeping staff Y sprayed

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a bedside table with Lysol Foaming Disinfecting Spray and then immediately wiped down the bedside table. Housekeeping staff Y then sprayed the resident's dresser with the Lysol Foaming Disinfecting spray and immediately wiped down the dresser. Housekeeping staff Y sprayed the Lysol Foaming Disinfecting Spray on the resident's toilet seat, the top rim of the toilet, the paper towel dispenser and the face bowl. Housekeeping staff Y wiped down the paper towel dispenser within a minute of spraying it with the spray. After cleaning the toilet bowel with an abrasive cleaner housekeeping staff Y re-sprayed the toilet seat and immediately wiped it down. During interview with housekeeping staff Y at that time, the staff stated the facility used the Lysol foaming disinfecting spray both as a sanitizer and disinfectant. Housekeeping staff Y stated the contact time was 30 seconds.

Review of the information on the Lysol Foaming Disinfecting Spray read: To sanitize/disinfect, pre-clean the surface, spray the surface until it was covered with foam. To sanitize leave for 30 seconds before wiping.

On 1/30/14 at approximately 8:00 A.M. maintenance staff X stated the facility used the Lysol Foaming Disinfecting Spray both as a sanitizer and disinfectant.

The facility's Medication Administration Policy revised 8/2012 included medications ordered for another resident would not be administered to another resident.

The facility's Handling Linens to Prevent and Control Infection Control Transmission revised 11/18/13 included according to F 441 a nursing

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F 441	Continued From page 116 facility must have an infection control program which included policies to prevent the development and transmission of diseases and infections in nursing facilities. The facility failed to track all infections, failed to follow the manufacture directions contact time for the Lysol Foaming Disinfecting Cleaner and failed to prevent cross-contamination when administering medications.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. Based upon observation and interviews the facility failed to ensure 1 of 2 dryers functioned properly for 3 of 6 days of the survey. Findings included: - On 1/29/14 at approximately 8:15 A.M. observation revealed the facility had 2 dryers located in the basement of the facility. Further observation revealed the lid of 1 of the dryers (located near the table where staff folded linens/clothes) was open and the dryer was drying clothes/items. Further observation revealed the compartment that held the pilot light was visible and the blue flames from the pilot light were observed when the dryer was in operation. Observation revealed an opening within the	F 456		

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compartment that held the pilot light would allow items to accidentally enter the compartment with the pilot light. Laundry employee HH stood in front of the dryer folding linens. During interview with maintenance staff X at that time, he/she stated he/she had worked at the facility for 3 years and the lid was always open when the dryer was in process.

On 1/30/14 at 8:45 A.M. observation revealed the dryer was on, the lid propped open and the pilot light with the blue flames was seen. Laundry staff HH stood next to the dryer folding items. Laundry staff HH stated he/she had worked at the facility for approximately 5 months and the lid was always open. Maintenance staff X closed the lid, walked to the back of the dryer to obtain the serial and model number of the dryer. Maintenance staff X was at the back of the dryer for a couple of minutes, then walked to the front of the dryer and stated the dryer was not getting enough airflow which was why the lid was opened during operation. Maintenance staff X opened the lid and observation revealed the pilot light was out. Maintenance staff X stated he/she performed all of the maintenance on the dryer and he/she did not have an instructional manual for the dryer.

On 1/30/14 at approximately 12:04 P.M. via a telephone conversation with technician II (representative of the manufacturer of the dryer), he/she stated it sounded like the access panel was missing. Technician II stated the access panel concealed the pilot light compartment which would not allow one to see the pilot light when the dryer was on. Technician II stated without the access panel the dryer would work "funny". Technician II stated there was no risk to the dryer, but items could enter the pilot light

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F 456	Continued From page 118 compartment creating a fire hazard. On 1/30/14 at approximately 1:45 P.M. observation revealed the dryer was not in operation. Further observation revealed a built up of lint on the inside of the lid. On 2/3/14 at approximately 9:00 A.M. observation revealed the dryer in operation, the lid propped open and the pilot light was visible. The facility's Accident Prevention policy revised 7/2012 included the facility would identify hazards and risks, would evaluate and analyze the hazards and risks, and the facility would implement interventions to reduce hazards and risks. The facility failed to ensure the dryer functioned properly.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility had a census of 74 residents. The sample included 18 residents. The facility failed to ensure 2 call lights functioned on 2 of 2 halls. Findings included: - On 1/27/14 at 11:00 A.M. observation revealed	F 463		

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the bathroom call light for one room (a shared room) on the north side did not visually or audible go off above the resident's door.

On 1/27/14 at 11:30 A.M. maintenance staff X stated the wire to the call light was loose which is why the call light did not light up outside of the room.

Observation also revealed 2 rooms side by side (shared bathroom) call light did not go off at the panel located at the north nursing station. Observation also revealed one of the shared rooms call light by the residents' bed did not go off at the panel located at the north nursing station.

On 1/27/14 at approximately 11:30 A.M. maintenance staff X stated the bulb was burnt out at the panel.

On 1/27/14 at approximately 11:00 A.M. 2 rooms (not shared room) on the south hall call lights did not go off at the panel located at the south nursing station.

On 1/27/14 at approximately 11:30 A.M. maintenance staff X stated the bulb was burnt out at the panel.

Review of the facility's call light maintenance log from 7/30/13 to 1/22/14 revealed staff documented on the logs call lights were operable, staff replaced bulbs at the nurse's station panel, staff replaced bulbs above the resident's room door but the log did not identify which call lights were checked and/or did not function.

During interview with maintenance staff X on

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F 463	Continued From page 120 1/27/14 at approximately 11:00 A.M. the staff stated he/she checked all call lights each month but did not document specific findings. The facility's Call Light Policy dated 6/2008 did not address preventative maintenance of the call lights. The facility failed to ensure all call lights functioned.	F 463		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: The facility identified a census of 74 residents. Based on observation, and interview, the facility failed to provide the residents with sufficient space for 1 of 1 dining rooms for 3 of 6 days on site of the survey. Findings included: - Observation on 1/23/14 at 11:46 A.M. revealed residents waiting for tables in order to sit down and consume their meal. There were 50 seats in the dinning room. On 1/29/14 at 11:21 A.M. residents stood in the	F 464		

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F 464	Continued From page 121 common area as they waited for seats to open up at the dining tables. On 1/30/14 at 11:35 A.M. residents stood in the common area as they waited for seats to open up at the dining tables. Interview on 1/28/14 at 4:40 A.M. with resident #2 stated there was not enough room in the dining room for everyone to eat at the same time. On 1/29/14 at 8:05 A.M. with resident #68 stated residents waited to eat until a spot opened at a table. On 1/30/14 at 7:47 A.M. an unsampled resident stated he/she went to the dinning room early for lunch and dinner in order to get a seat. On 1/30/13 at 7:43 A.M. dietary staff EE stated the residents sat where they wanted and seating was not a problem because the residents ate at different times. On 1/30/13 at 7:50 A.M. with direct care staff QQ stated he/she felt there was not enough space for all residents to eat at one time. The facility failed to provide a policy and procedure on dining arrangements. The facility failed to provide sufficient space to accommodate the residents who received meals in the dining room.	F 464		
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside	F 467		

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ventilation by means of windows, or mechanical ventilation, or a combination of the two.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 74 residents. Based upon observation and interviews the facility failed to provide adequate outside ventilation in 2 (#72, #58) of 2 residents room.

Findings included:

- On 1/30/13 at approximately 9:00 A.M. direct care staff N stated that resident #72's room (the resident resided on the south hall) did not have adequate ventilation. Direct care staff stated the temperature in the resident's room reached 90 degrees for the last 3 nights/days which caused the resident to be restless. Direct care staff N stated the facility had nailed the resident's windows shut so staff was unable to raise the window in the resident's room.

On 1/30/13 at approximately 9:30 A.M. observation revealed a fan on in the resident's room and the windows in the resident's room, as well in his/her bathroom would not open.

On 2/3/14 at approximately 8:45 A.M. resident # 58 whose room was next to resident # 72 and who shared the same bathroom with resident #58 stated his/her room was hot at times and he/she would like a fan in his/her room. Resident #58 stated his/her windows were nailed shut, therefore he/she could not open his/her windows. Resident #58 stated the facility nailed his/her windows shut to keep him/her from smoking in his/her room. The resident stated his/her

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F 467	Continued From page 123 windows were nailed shut for some time. Observation revealed the window closest to the resident's bathroom would not open as well as the bathroom window. On 2/3/14 at approximately 9:00 A.M. resident # 72 stated his/her room was hot at times and he/she could not open his/her windows because the facility had nailed them shut to prevent him/her from smoking in his/her room. On 1/30/14 at approximately 11:15 A.M. maintenance staff X stated 2 rooms on the south hall and 1 room on the north hall were nailed shut to prevent the residents from smoking in his/her rooms. Maintenance staff X stated resident #72 had complained of his/her room being hot and the resident's room was one of the rooms the facility had problems with maintaining the room temperature. The facility did not provide a policy regarding outside ventilation. The facility failed to ensure all rooms had adequate ventilation.	F 467		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		

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The facility reported a census of 74. Based on observation, interview, and record review, the facility's administration failed to manage the facility in a manner to meet the needs of all residents.

Findings included:

- The facility's administration failed to manage the facility in a manner to meet the needs of the resident's, as evidenced by the following citations:

Based on observation, record review, and interview, the facility's administration failed to address liability notice timely. Please see F156 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the conveyance of personal funds upon death within 30 days. Please see F160 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the amount of the surety bond for the personal funds account. Please see F161 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the allegations of abuse, neglect, and exploitation (ANE) was investigated and reported. Please see F225 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the development and implementation of ANE policy and procedures. Please see F226 for

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additional information.

Based on observation, record review, and interview, the facility's administration failed to address dignity for residents in the common living areas. Please see F241 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the housekeeping and maintenance services of the facility. Please see F253 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the facility maintained comfortable heating temperatures. Please see F257 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the development of comprehensive care plans. Please see F279 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the lack of obtaining a urinalysis sample in a timely manner. Please see F281 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the quality of care for respiratory assessment. Please see F309 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address activities of daily living for bathing

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services. Please see F312 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address urinary incontinence care and assessment. Please see F315 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address fall interventions and hot water temperatures. Please see F 323 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address medication behavioral monitoring and medication parameters. Please see F329 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address registered nursing (RN) hours. Please see F354 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address posting Full Time Equivalent in a prominent area. Please see F356 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address dining room table sanitation. Please see F 371 for additional information.

Based on observation, record review, and interview, the facility's administration failed to

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address timely Preadmission Screening and Annual Resident Review (PASRR) services. Please see F406 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the drug regimen review and pharmacy consultation. Please see F428 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address the disposition of expired medications. Please see F431 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address infection control, storage of used nebulizers, and disposal of soiled linen. Please see F441 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address maintaining facility equipment specifically the central heating equipment. Please see F456 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address malfunctioning call light system. Please see F463 for additional information.

Based on observation, record review, and interview, the facility's administration failed to address dining room accommodation for residents. Please see F464 for additional information.

Based on observation, record review, and

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F 490	Continued From page 128 interview, the facility's administration failed to address the facility ' s ventilation particularly the nailing shut of resident room windows. Please see F467 for additional information. Based on observation, record review, and interview, the facility's administration failed to address the lack of yearly staff proficiency reviews. Please see F497 for additional information. Based on observation, record review, and interview, the facility's administration failed to address the lack of disaster drills. Please see F518 for additional information. Based on observation, record review, and interview, the facility's administration failed to address the lack of an effective Quality Assurance (QA) program in place to monitor and implement corrective actions for issues identified. Please see F520 for additional information. The facility's administration failed to manage the facility in a manner to meet the needs of all residents.	F 490		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews	F 497		

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F 497	Continued From page 129 and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents. Based on record review and staff interview, the facility failed to provide documentation of performance reviews for 3 of 3 employee records reviewed. Findings included: - Record review of employee files for direct care staff O, Q, and S, on 2/3/14 lacked evidence of current employee performance review for the year 2013. Interview on 2/3/14 10:00 A.M. with administrative nursing staff stated performance reviews were completed 90 days after employment and yearly. The performance reviews identified strength and improvement needs. Staff training was identified by employee performance reviews. The facility failed to provide documentation of performance reviews for education and training needs.	F 497		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518		

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staff; and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents. Based on record review and interview the facility failed to provide documentation the facility provided periodic training of employees in emergency procedures and failed to document unannounced staff drills.

Findings included:

- Record review on 2/3/14 revealed staff performed a fire drill on 9/6/13. Fire alarm testing was done on 6/22/13, 12/20/13, and 1/24/14.

Interview on 2/3/14 at 12:25 P.M. with maintenance staff X stated fire alarms were tested monthly and recorded but not fire drills. She/he stated fire drills were performed monthly and he/she provided tornado in-services but did not document. She/he denied providing other disaster drills/in-services as listed in the policy and procedure including elopement.

The Disaster Policy and Procedure revealed employees were trained and able to effectively and efficiently evacuate the facility. Evacuation training included identification of alternate exit routes, knowledge of designated outside meeting location, and methods to account for residents, staff and visitors present in the building at the time of the emergency. Employees were trained and able to efficiently and effectively seek shelter inside the facility in the case of a tornado or other dangerous storm. Training also included the

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F 518	Continued From page 131 appropriate action the facility should take in the case of fire, utility outages, earthquakes and other identified emergency conditions. Fire drills were conducted once each month at different times including day, evening, and night time hours. Drills could include simulated and actual evacuation to a predetermined meeting place. Other emergency drills including tornado and severe weather drill were carried out at least annually. The facility failed to provide evidence the facility performed disaster education and drills.	F 518		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		

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and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents. Based on observation, record review, and staff interview, the facility Quality Assessment and Assurance (QAA) committee failed to identify and remedy issues that required action plans.

Findings included:

- During an interview on 02/03/14 at approximately 2:30 P.M. with administrative staff A stated the QAA committee reviewed missing items list, inventory lists, and resident council meeting minutes. The QAA committee did not review care plans but the Minimum Data Set (MDS) coordinator brought identified concerns to the QAA meeting. The Director of Nursing (DON) tracked and trended infections and identified any staff training that was required. Department heads reviewed six charts weekly to ensure charting was complete. The QAA committee also reviewed complaints, the 2567 (facility survey results), grievances, infection control, safety reports, and addressed concerns. Each department head communicated meeting information to their staff.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed timely liability notice. Please see F156 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA

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committee addressed the conveyance of personal funds upon death within 30 days. Please see F160 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed the appropriate monetary coverage of the surety bond. Please see F161 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed abuse, neglect, and exploitation (ANE). Please see F225 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed the development and implementation of abuse, neglect, and exploitation. Please see F226 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed the dignity of the residents in common living areas. Please see F241 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed housekeeping and maintenance services. Please see F253 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed comfortable heating temperatures. Please see F257 for

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additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed development of comprehensive care plans. Please see F279 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed obtaining a urinalysis sample in a timely manner. Please see F281 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed quality of care issue specifically respiratory assessment. Please see F309 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed services for bathing. Please see F312 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed urinary incontinence and urinary assessment. Please see F315 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed falls and hot water temperatures. Please see F 323 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA

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committee addressed medication behavioral monitoring and medication parameters. Please see F329 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed registered nursing (RN) hours. Please see F354 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed the posting Full Time Equivalent in a prominent area. Please see F356 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed dining room table sanitation. Please see F 371 for additional information.

Based on observation, record review, and interview, the facility failed to ensure that the QAA committee addressed timely Preadmission Screening and Annual Resident Review (PASRR) services. Please see F406 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed drug regimen review and pharmacy consultation. Please see F428 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed the disposition of expired medications. Please see F431 for additional

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information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed infection control, storage of used nebulizers, and disposal of soiled linen. Please see F441 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed maintaining facility equipment, such as the central heating equipment. Please see F456 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed malfunctioning call light system. Please see F463 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed dining room accommodation for residents. Please see F464 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed ventilation, specifically nailing shut resident room windows. Please see F467 for additional information.

Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed effective administration of ANE allegations. Please see F490 for additional information.

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F 520	Continued From page 137 Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed lack of yearly proficiency reviews. Please see F497 for additional information. Based on observation, record review, and interview, the facility failed to ensure the QAA committee addressed the lack of documentation of monthly fire drills and annual disaster drills. Please see F518 for additional information. Based on observation, record review, and interview, the facility failed to have an effective Quality Assurance program in place to monitor and implement corrective actions for issues identified.	F 520		